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Active Communities

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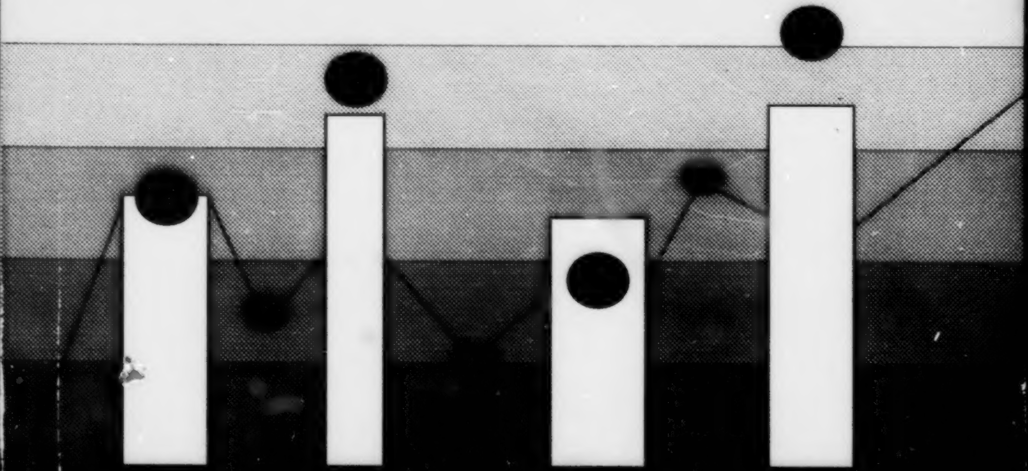

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Active Communities

A STUDY OF LOCAL COMMUNITY HEALTH AND SOCIAL SERVICE CENTRES IN CANADA IN 1988

by **Jean-Bernard Robichaud**

and **Claude Quiviger**

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Foreword

In choosing *Active Communities* as the title, the authors of this book point to the dynamic but positive nature of the subject they have undertaken to study.

Identifying, classifying and analyzing the agencies that meet their carefully conceived definition of centres that serve communities in socially constructive ways is a formidable undertaking. Earlier endeavours in the 1960s and 1970s by federal and provincial governments to deal comprehensively with community-based social services failed to come to fruition. In large part this was because of a lack of in-depth knowledge of the range and nature of the health and social service needs of the country's diverse communities, how they were being met by existing programs and indeed, how they could be met by more innovative and participatory approaches. The challenge of bringing conceptual order out of the complex web of community service data has, herewith, been taken up by Jean-Bernard Robichaud and Claude Quiviger, whose combined professional attainments and experience admirably qualify them to carry out this demanding enterprise.

Their work has been based on a rich store of personal knowledge, a thorough review of the relevant literature on community services at home and abroad, interviews with some 70 authorities on community programs from all ten provinces and the formulation of a hypothetical community centre model as a guide for the approach they would take in the enquiries they were pursuing.

In describing their model, the authors reveal that their philosophy of community intervention is based on a global approach that is "open to new perspectives and covers a range of forms and types of intervention favouring interdependence, solidarity and self-help among the members of a community." Armed with a sound conceptual basis for the enterprise, the research team cast their survey net widely enough to embrace over 1,100 community agencies from which they were able to secure 368 for detailed analysis. Of these, 36 were found to be essentially community health centres, 190 offered social services and 140 were classified as combined health and social service centres.

The researchers' analysis is multidimensional and rigorous and their findings are presented in concise commentary supported by some 97 uncluttered tables.

In addition to its definitive findings, the study has opened the field to a range of additional inquiries which it will predictably inspire. Meanwhile it "gives individual centres and the thousands of administrators, volunteers, managers and staff members an opportunity to take stock of the organizations in which they work, to strengthen their community orientations and to refine their interventions."

In sponsoring this project and publishing its findings, the Canadian Council on Social Development has maintained a 70-year tradition of leadership in promoting the enhancement of human well-being in all Canadian communities.

Dr. Richard Splane
Professor Emeritus
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Preface

After more than half a century of involvement in social research, consultation and discussion, the Canadian Council on Social Development (CCSD) remains committed to participating in current debates on the organization of Canada's social and health care system and health and social service policies.

Specifically, the CCSD would like to contribute to the sometimes lively, indeed stormy, debates on the delivery of local health and social services, for the relevance of general policies must be tested ultimately on the immediate ground of local services, the ground of the ordinary conduct of everyday life. Beyond the images and the speeches, it is the lived reality of these local services that reveals society's real orientations and policies and determines in large part the quality and effectiveness of our social and health care system.

One of Canada's distinctive features is that under the division of powers between the federal and provincial governments, health and social services, among other things, fall under provincial jurisdiction, which explains the great diversity of operating methods that have existed – and continue to exist – in the different provinces. This exploratory and descriptive study addresses the situation of a number of local community health and social service centres across Canada and discusses future prospects.

Terrance Hunsley
Canadian Council on Social Development

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In addition, we would like to express our heartfelt gratitude to the following individuals and organizations:

- the local community centres from across Canada that agreed to fill out our questionnaire;
- the 70 people from all ten provinces who agreed to interviews, and our colleagues Terrance Hunsley and Harry MacKay, who conducted many of the interviews;
- the Community Services Research Centre at Université Laval in Quebec City which gave us flawless logistical support, with special thanks to Gabrielle Carrier for her contribution in the areas of methodology and data analysis;
- the Fédération des Centres locaux de services communautaires du Québec and the New Brunswick Department of Health and Community Services for financial support;
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Introduction

Over the past 20 years, a number of commissions and task forces have recommended the development of local community health and social service centres in Canada.[1] In 1976, the Canadian Council on Social Development (CCSD) published a study entitled *Community Multi-Service Centres*.[2] More recently, the CCSD, in association with a number of national and provincial organizations, organized a national conference on the improvement of community health and social services.[3] In 1987, the CCSD published a study on the role of local government in the delivery of health and social services in Canada.[4] Also in 1987, the Canadian Association for Public Health held a series of provincial workshops on improving community health services.[5]

There is a large body of literature on community services, especially in France, Great Britain and the United States.[6] These few bibliographical references, selected from many others, indicate the existence of theoretical work on community health and social service centres. But what is the situation on the ground? What is the state of development of community centres in Canada in 1988?

The present work is an exploratory and descriptive study of a certain number of centres which offer health and/or social services using what may be called a community approach. Centres from all ten Canadian provinces are included; we were unable to include the Yukon and the Northwest Territories due to an insufficient number of responses.

A Central Question

Our starting point was the following question: there is a certain body of literature dealing with community services and there are thousands of local bodies which call themselves community organizations. **Is there a relationship between these two levels, between the literature and theories pertaining to community action and the concrete reality**

of organizations that provide health and social services using a community approach? What is generally referred to as "community services" appears as a highly complex, diverse, changing reality, difficult to pin down and to understand. Indeed, the organization of services at the local community level is as complex as social life itself, with its many and varied daily interactions. This explains the purely descriptive and exploratory nature of our study and the guarded character of our forecasts. Readers will therefore understand that, when we propose a theoretical framework based on our survey of the literature and our practical experience in the field, we do so tentatively and with great caution.

We began by identifying some fifty variables or dimensions related to community centres which we believed deserved examination. Despite the heterogeneous nature of the community sector, the results obtained allowed us to identify some main characteristics of the 368 community centres which participated in the study. They also allowed us to determine the extent to which the actual reality of these centres corresponds to the theoretical framework. We hope this work will contribute to a more accurate knowledge of the reality of community health and social services as they are conceived and as they exist in all ten Canadian provinces in 1988. The information collected falls into three major categories: the orientations of the community centres; their organization and operations; their funding.

The 49 questions were aimed essentially at obtaining the most faithful possible description of certain characteristics of these community health and/or social service centres.

Goals

This study aims to take stock of the state of development of community health and social services in Canada's provinces and to present an overview of such services across the country. The Canadian Council on Social Development hopes this work will improve the documentation available on a new, largely unknown phenomenon whose implications for Canadian social policy have received little empirical study to date. This evidence will provide a basis for the CCSD's future actions in the promotion of community health and social services.

We also hope that community centres will obtain more detailed knowledge of their own characteristics and use this data to more clearly define their orientations, strengthen their modes of organization, better adapt their services to the needs of their respective communities and elaborate development strategies to give them still greater impact within the health and social services network.

These goals are at once ambitious and modest. Our study has a number of important limitations of which we are well aware. It remains quite superficial in its treatment of individual provinces. Specific studies on each province would give us more exact knowledge of the subject. What a Canada-wide study loses in depth, however, it gains in breadth. This is the first study to address directly a large number of community centres (1,115), making it possible to obtain a description of the phenomenon at the national level and to identify some prospects for development at this level.

The present report is divided into three parts:

- theoretical and methodological framework;
- findings; and
- future prospects and questions to be resolved.

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Chapter 1

COMMUNITY HEALTH AND SOCIAL SERVICE CENTRES

The term *community health and social service centres* defines our field of investigation. Services related to recreation, education, justice and the economy have been excluded from this study; only organizations which acknowledge a mandate to provide health and social services are dealt with. The term *health and social services* is used here in a very broad sense, along the lines of the World Health Organization's ecological definition of health. It encompasses not only services provided by professional staff within a systematic problem management and resolution process, but also community self-help, advocacy, community support and improving health and social conditions in the environment. As community centres are the subject of this study, traditional organizations and major health care and social service organizations have been excluded. The criteria used to more clearly delineate the field of study are presented in the chapter on methodology.

Before proposing a community health and social service centre model as a theoretical hypothesis (which shall be the subject of the second part of this chapter) we must clarify the following concepts on the basis of the literature: *community, community intervention, community centre*.

PRELIMINARY CLARIFICATIONS

COMMUNITY

The community approach is based on the thesis that the community possesses a fund of the internal dynamism necessary for its own development; that it can better mobilize citizens and more effectively pursue needed social change than can isolated individual efforts or measures originating with or imposed by outside professional or administrative authorities.

A community may be considered a group of people joined by social systems and living within a defined territory. This group shares common objective conditions (territory, geographic and political environment) and common systems of relationships (social institutions, values and interests). The higher the level of interactions, the stronger will be the feelings of community identification and belonging.

According to some writers, community involves three major factors: territory, common interests and sense of belonging.[1] These parameters are in no way mutually exclusive; they are, rather, complementary and in constant interaction, representing constitutive elements which are always present to varying degrees in real communities. Failure to distinguish these factors and lack of recognition of their complementary nature create some confusion in the definition of community and community services.

Territory

The definition of community is closely bound to the idea of place: we assume that people living on the same territory share certain common characteristics due to the fact that they live under the same environmental conditions. The premise underlying intervention at the community level is that a shared geographic space of relatively limited size allows us to speak of community, and this notion may serve as a force for change and for the improvement of living conditions. This is why all service-providing organizations that describe themselves as engaging in community action define themselves in relation to place in one way or another. Community services are, by definition, local services, defined on a local basis and in relation to a population residing on a given territory or sharing common characteristics. The idea of place is therefore an important element for understanding the concept of community and consequently for defining the community approach.

Despite its importance, however, the idea of place is not sufficient by itself to explain the bonds created among the people, groups and institutions occupying a common territorial space. Human groups within a given territory are heavily conditioned by the organization and constraints of the space they occupy. They reflect, to some extent, collective economic, social and cultural conditions, as well as the territory's geopolitical situation. There are close connections among living conditions, a given community's specific characteristics and the organization of the space it occupies.

At the local level, land-use and control over space have social, economic and political dimensions which must be taken into account in any community development approach. The idea of community therefore implies much more than simply an unconnected collection of people; it involves at a basic level land-use and the structured relations existing among the occupants of a given territory. Interaction among community members breeds a certain identification with the community, giving rise to common interests and a sense of belonging.

Common Interests and Sense of Belonging

The idea of common interests shared by a group of people constitutes another basic element of the concept of community (community of interest). All the people occupying a common territory do not necessarily share the same characteristics, values and affinities. Some groups form and develop more on the basis of shared characteristics or affinities than of common territory. The idea of territory is still present and necessary in the case of communities of interest and of belonging, but it then represents only a secondary aspect of community identity. To properly understand the nature of a community, an observer must recognize the convergent and divergent interests found in the community and understand the strength of these interests.

A community is also based on what is called a sense or feeling of belonging; in other words, the identification members feel with their community. Feeling of belonging to a community and community of interest reinforce each other. Shared interests among community members increase interactions among them and lead to a greater sense of belonging to a community. Conversely, networks of belonging (family, ethnic group, religion, neighborhood, etc.) will lead to increased interaction among community members. To use an analogy, these two components of community – interest and belonging – are the mortar which binds people together within a territorial and relational space. Communities of interest and of belonging may be so dispersed across a territory that the idea of common place loses much of its relevance. The community approach cannot therefore be reduced to place, for a territorial logic pushed to its extreme could lead to so restrictive a definition of community as to exclude communities of interest and of belonging.

For purposes of intervention, a territorial community of sufficient size can generally support communities of interest and belonging under the following conditions:[2]

- a stable, mostly long-established population;
- the existence of kinship networks;
- correspondence between place of residence and place of work;
- a relatively homogeneous population in terms of class and socioeconomic level;
- relative ethnic homogeneity;
- geographic isolation from other populations;
- a physical organization of space which favours the development of neighborhood and gives the territory a distinct identity;
- a large number of local organizations and associations; and
- external pressures or threats against the community (a transient factor).

The stronger the convergence of the three factors mentioned previously (territory, common interests, sense of belonging), the more likely we are to find a real, vigorous community. Modern means of communication, which put all citizens in permanent contact with the entire world, tend to diminish the sense of identification with a specific piece of territory and the feeling of belonging to a community. In addition, the anonymity and mobility prevalent in urban environments tend to relativize the territorial factor to a great extent; they may, however, lend greater importance to the factors of interest and belonging. Finally, some analyses of community groupings[3] have concluded that such groupings tend to be increasingly transient and specific in purpose; today's allies on one issue may well find themselves on opposite sides of another issue tomorrow.

The idea of community is therefore not unitary, simple or static. It is in fact a highly fluid and dynamic reality. Nobody questions the importance of community, nor the need to belong to community groupings for survival, in terms of both basic needs and emotional sustenance. But we must keep in mind that there are many types of communities. To respond adequately to a variety of community needs, we must diversify our organizational forms and community intervention strategies. If society invests and organizes all its community resources strictly on the basis of a territorial model, what shall become of other community problematics which relate more to shared interests or belonging and transcend territorial boundaries? This question is far from academic: it points to one of the major difficulties in dealing with a host of community needs which cannot be addressed adequately if we base ourselves primarily on the territorial dimension (e.g., battered women, the disabled, juvenile delinquents, senior citizens, the unemployed, welfare recipients). We will examine how the community centres studied deal with these issues in their approaches to their specific communities.

A Definition

The preceding discussion lays the basis for a sociological definition of community. We propose a definition taken from Roland L. Warren which incorporates both the physical factor (territory) and the psychological factor (common interests or belonging): "We shall consider a community to be that combination of social units and systems which perform the major social functions having locality relevance."[4]

Warren identifies five major functions of community:[5]

- production-distribution-consumption;
- socialization;
- social control;
- social participation; and
- mutual support.

As the focus of our study is on health and social services, we shall look only at the last point, mutual support. This refers to interdependence among the members of a community, that is to say the types of exchanges and acts of assistance which occur when individual or collective equilibrium is threatened by certain stresses, such as illness, unemployment, family crises, accidents, death, etc. We find various types of community responses to difficulties of these kinds. Health and social services in particular operate at the community level and some of the organizations that provide these services profess a community approach. It is these centres that are the subject of our study.

A community, then, is a group of people joined by social systems and living within a defined territory. Some of the items on the questionnaire were designed to explore the practical implications of this concept of community for the centres studied and to define the types of communities in which these centres are located. We consider the variables relating to type of community to be determining and we shall attempt to establish whether the centres' characteristics vary according to the type of community in which they are located and the definition of community that they use.

COMMUNITY INTERVENTION

Community intervention as a whole is concerned with the need to live in an environment which is on a human scale, a setting which responds to needs for a quality environment, for belonging, for social communication open to emotional, not only functional, considerations. Community intervention constitutes a new way of conceiving problem analysis and resolution. According to the Barclay Report,[6] published in Great Britain in 1982, community intervention is based on the premise that ordinary individuals and communities have more resources, potential, skills and concern for helping and supporting each other than is generally supposed. For advocates of community intervention, the community becomes the main source of help and support for both groups and individuals. Again according to Barclay, if all acts of assistance and mutual support among the members of a community could be added together, we would find that formal institutional services represent only a small portion of the mutual assistance proffered in a community.

Towards a Definition of Community Intervention

A Global, Multi-service Approach

Community intervention is global and comprehensive, which is to say that it involves both individuals, with their personal needs for specific concrete services, and the community as a whole, with its collective structural needs. It relies more on community dynamism than on the specialization and expertise of the service-providers.

We can distinguish three levels in a community approach, though these are always interrelated:

- the individual with his or her specific concrete individual needs. Community intervention considers any individual as a whole person who cannot be reduced to the problem displayed; hence the need for a global, multi-service approach. In addition, individual problems and needs are not reduced to a cold, specifically technical definition; they are seen as having emotional, economic, cultural and social ramifications. At the very least, solutions should integrate health care and social services. A range of concrete, individual services, both preventive and therapeutic, are required at this first level, for the user is a whole human being.
- the individual in his or her environment. No person is an island and the quality of an individual's environment is a basic factor conditioning his or her development or lack thereof. Community intervention cannot, therefore, limit

itself to providing immediate service to individuals. This outlook at once opens up more global perspectives for intervention, with a view to integrating the individual into his or her environment and modifying that environment. These dimensions of community intervention should translate into a wide range of comprehensive services at the community level and explicit provision for user participation in the elaboration of services.

- the environment itself and existing organizational structures in the milieu. If there are shortcomings in the environment that are a source of problems for individuals, it is not enough to act at the individual level: intervention must address the structural causes. This leads to the "social change" dimension of community intervention, which consists of democratically mobilizing the community for joint action. This more political level of community intervention aims to modify living conditions or environmental conditions and deals with structural change. Community intervention at this level often questions the powers that be, calling for new collective programs, improvements to already existing programs, or new legislation.

Complementary Strategies in Dynamic Equilibrium

Just as there are a number of levels to community intervention, we find different types of community services depending on whether the emphasis is placed on individual or collective considerations. Community intervention is characterized not by one extreme or the other but rather by equilibrium, a dynamic process which strives to integrate the three dimensions described above.

From Service to Mobilization

In actual practice, individuals who are not yet aware of the social and collective dimensions of their situation, which they often share with many other individuals, frequently gain such awareness in the process of receiving individual services, if the service provider attempts to sensitize them to these considerations. Thus, the individual becomes gradually more open to collective initiatives aimed at changing the situation. The community approach is basically a process of awareness-raising, learning and education in and through action. This process, which is characterized by constant dynamic interaction between the collective and individual dimensions,[7] is almost always applicable, whether the community is based on territory or on interests and belonging. The approach's basic concepts may be summarized as follows:

- individual development and collective participation in interaction;
- control by the community of decision-making powers over the services it receives;
- a global, multidimensional approach; and
- prevention and community development.

A Rigorous Intervention Process

Community intervention is in no way an anarchic activity subject to the caprices and impulses of the moment. It is a long-term process which requires genuine rigour to succeed and must encompass a number of stages:

- objective analysis of needs;
- formulation of precise goals;
- acquisition of the information and knowledge required for intervention;
- development of intervention methods and techniques;
- the intervention itself; and
- evaluation.

In reality, this process is not linear but rather iterative, since it is not an intellectual exercise but a series of actions aimed at promoting concrete individual and social change. Often, we find a number of stages in progress simultaneously. What is important is that no stage be neglected, for in fact each depends on the others. These principles of community intervention should find concrete expression in the following areas:

- the type and range of services offered by a community centre;
- access to the centre;
- the type of staff employed by the centre;
- public representation on the Board of Directors and public participation in defining service orientations; and
- the operations and management of the centre.

Underlying Orientations

Thus defined, community intervention, with its ideological horizons, its understanding of needs, and its vision of individual and collective change, should express certain basic orientations towards the public and the role of government. Coherent application of these orientations demands some specific forms of community centre management and operation. Ten of the questions on the questionnaire were aimed at identifying respondents' basic orientations towards the public and the role of government.

Orientations Towards the Public

To identify the orientations of the centres studied, we began with a question on the centre's main areas of intervention:

- health services only;
- social services only; or
- integrated health and social services.

In addition to its main fields of intervention, a centre may offer services in other areas, such as legal aid, education or housing.

While this question is related to the centre's operations, we still consider it essentially one of orientation because it provides a first indication of a basic aspect of community intervention, namely the extent to which it employs a global, multi-service approach.

Our hypothesis is that insofar as a centre has a diversified mission which includes services in different sectors, it will be more likely to use intersectoral and multidisciplinary approaches; it will encounter greater difficulty in practicing any type of compartmentalization; and it will be more responsive to the community and its diverse needs. In other words, incorporating services in different fields will increase a centre's sensitivity to community needs, for it will then be penetrated by a number of ideological currents, a variety of professional disciplines and traditions, and various methodological instruments.

Community intervention espouses a global approach which favours comprehensive rather than specialized responses. We would also expect that, by virtue of the community approach, centres would not limit themselves to offering therapeutic services but would incorporate other dimensions as well: prevention, education and social action. We would therefore expect to find quite a wide range of services.

Insofar as it encompasses a number of dimensions (therapeutic and preventive, individual and collective), community intervention is oriented towards public participation and involvement in the identification and analysis of health and social service needs in the community. In addition, community intervention should give community members an opportunity to participate in making decisions about the establishment of programs. There are a number of possible mechanisms for democratizing community centres, from advisory boards with no decision-making power to formal elected representation for users on the Board of Directors. In our view, the more diversified and powerful the mechanisms for public representation are, the greater the likelihood that community intervention will reflect community needs.

Finally, community intervention is informed by a two-sided concern with respect to the elaboration and management of goals. On the one hand, it is important that the goals be accepted by centre management and staff, for they cannot promote the autonomy of individuals or of the community if they do not share their community centre's goals, or if they work in an autocratic and constraining environment. On the other hand, the centre's goals must be accepted by the population it serves, for a centre cannot claim to be working for citizens' autonomy, or to want to make citizens into full partners, without attaching great importance to the appropriation of these goals by the citizens themselves — in other words, if these goals remain the exclusive property of centre management and/or staff. But while this is an important question for community intervention, we shall not be able to provide a precise, definitive answer within the scope of this study.

These considerations bring us to another basic dimension of the community approach, the staff's perceptions of community members. This is also a very important aspect of orientation. We included a question aimed at identifying the centre's attitude towards the population. Are community members perceived primarily as:

a) clients or patients to be helped or healed?
b) citizens and beneficiaries who are entitled to the services provided by the centre?
c) citizens with a capacity to organize and to become partners in the search for solutions to their problems and those of the community? This third view, which seeks to strengthen community autonomy and control, seems to us to be more consistent with the community approach than the other two. It is also the point of view advanced in the Barclay Report.[8]

Analysis of staff members' perceptions will allow us to determine the connection between a centre's formal orientations and the real types of relationships it develops with its community.

Views of Centres on Role of Government

At present, there are three prevalent attitudes towards the role of government, the representative of the State. As each of these currents of thought refers us to different conceptions of the role of government with respect to individuals, the family and the community, each has different implications for the development of community centres. We are therefore dealing with three different conceptions of government action and of the development of health and social services.[9] None of these currents is found in a pure state, even if we can isolate the characteristics of each at a theoretical level. In reality, they appear intermeshed, sometimes within the same individuals or groups.

a) The Neo-liberal Approach

Neo-liberal ideology questions the effectiveness of social services and social policy as a means of redistributing wealth, leading it also to question the public character of such services and their universality. This current of thought emphasizes individual responsibility and favours selectivity, privatization, and the establishment of market mechanisms to deliver services. The neo-liberal current holds that the State should reduce its role and cut back its activities to a bare minimum, involving itself as little as possible in the development of public services. According to this ideology:

- government should allow the law of supply and demand to prevail between health care or social service professionals and clients;
- government should provide minimal funding for the private organizations, non-profit or otherwise, assigned the task of delivering services; and
- government should play no role in managing and defining the orientations of these organizations.

b) The Welfare State Approach

According to the State-oriented approach, which has spawned the panoply of programs associated with the welfare state, the State must play a central and pervasive role in health and social programs. "The response to social needs is conceived here as a social right, based not on individual responsibility or personal fault but on perils and needs."[10] This approach aims to shield all citizens from insecurity and major social risks and makes the State the guarantor of these social rights. In this approach, the State is interventionist and plays a more or less direct role in managing services and programs.

The practical implications of this view may be summarized as follows:

- the government should define strategies and specific programs at the local community level. In Canada, Quebec's CLSCs are the most obvious example of this state-oriented approach;

- the government should provide all the funding for community centres; and
- the government should be involved directly in managing and defining the orientations of community centres.

In the State-oriented or welfare state approach, the government is the architect of community intervention. Community intervention is an official, public process, directed strongly by the State and funded heavily by the public purse.

c) The Community Approach

The Barclay Report, to which we have already referred, provides a fine illustration of the community approach. This approach considers it important to preserve and indeed expand acquired social rights: to do so, the State must maintain an active role, for it is the only possible guarantor of collective social rights. But the State and its technocratic bureaucracy should not monopolize the process of defining and providing services. The community approach espouses the "resocialization of social security mechanisms"[11] and community control of the instruments of intervention. This means that health and social services can be controlled at the local level, which "necessitates a decentralization of decision-making powers"[12] and requires participatory mechanisms to give citizens and beneficiaries control over services.

The community option may be expressed in the following four statements:

- the government should grant community centres official recognition by providing them with a specific legal framework limited to general orientations, goals and criteria;
- the government should delegate real and significant powers to the centres' Boards of Directors (decentralization);
- the government should provide substantial funding, but not the centres' entire budgets; and
- only a minority of the members of the centres' Boards of Directors should be government appointees.

Given that cooperatives represent an original vision of the community approach and are one of the models used to deliver health care in at least one province (Saskatchewan), we wanted to obtain respondents' reactions to the recommendations of a national task force on the development of health care cooperatives.[13] Analysis of the answers to this question will enable us to assess whether the cooperative model represents a viable alternative for the organization of community services.

Study of the orientations of community centres should prove enlightening because it will bring certain ideological assumptions to the surface and improve our understanding of the state of theoretical development informing the concrete actions of community organizations in their relations with the public. Like values and attitudes, however, orientations do not always determine actions and we may well find some contradictions between explicit orientations and actual practice. But we shall attempt nonetheless to establish connections between orientations and concrete organizational forms in community health and social service centres.

COMMUNITY CENTRES

Community intervention operates through organizational models aimed at making services, activities and programs available to the community, with the participation of the community. Specifically, we have included under the heading of community health and social service centres those public and private non-profit organizations which are legally incorporated and profess to practice community intervention. In addition to the centres' orientations, two major questions will be studied: operations and funding.

Operations

To understand the centres' operations, we have attempted to obtain information on the organization of their programs of activities and their management practices. Operations, as defined here, also include the supervision of the health care and social service professionals and staff delivering the services.

A community centre that seeks to promote community autonomy must adopt internal operating methods consistent with the goals it pursues.[14] In terms of a community centre's operations, promoting community goals implies:

- significant community participation in the identification of needs, choice of programs and services, and evaluation; this participation goes beyond (but does not exclude) representation on the Board of Directors and rests on a basic perception of citizens as partners, not simply clients or beneficiaries;
- work organization based on multidisciplinary work teams: individual or single-discipline organization is inadequate for implementing a global community approach, with its many facets and levels;
- effective but flexible implementation of procedures and instructions; in the long term, rigidity proves to be counter-productive and autocratic, and it fails to leave room for a partnership role for the public; on the other hand, laxity admits disorder and arbitrariness, closing the door to democratic public participation;
- including types of staff positions relevant to community intervention; this means, for example, community workers but also volunteers and self-educated workers;
- a wide enough range of services and programs to cover the preventive and collective dimensions of intervention, not just the therapeutic dimension;
- a systematic effort to cooperate and work together with other community organizations, not only those active in health and social services but also educational institutions, municipal and socioeconomic organizations, social clubs, etc.;
- physical access for the public in terms of opening hours, emergency services, location, lay-out, means of transportation and communication; and
- a method of payment for doctors which is not tied to the number of acts performed but instead leaves them enough latitude in the use of their time to adopt a more global approach and perform collective preventive interventions: salaries for doctors or at least service periods.

The questions relating to operations do not cover all the matters mentioned above in an exhaustive way. They do, however, provide information on:

- the type of staff and their ability to serve clients from minority ethnic groups in their own language;
- access to the centre;
- the Board of Directors, its composition, its operations;
- the organization of the work of service providers;
- activities, services and programs; and
- cooperation between the centre and other intervention resources.

All these multiple-choice questions were based on a community centre model the research team considered a hypothesis to be tested. The selection of possible answers covered both the operating practices consistent with our community approach hypothesis and more traditional methods that are less open to community needs and community participation.

Let us take, for example, the question of access to illustrate our approach. Four of the questions were aimed at determining accessibility: a factual question on the centre's opening hours on every day of the week (when and how many) and three questions calling for more subjective and qualitative assessments. On the basis of these questions, we were able to construct an accessibility index by weighting the various factors. For purposes of illustration, we shall consider one of the questions here, the one relating to opening hours. On the one hand, we can say, at a general level, that a centre with longer weekly opening hours is more available to serve the needs of its community than one with shorter hours. Thus, a centre that is open to the public 60 hours per week would be considered more available to serve users' needs than one which is open only 30 hours. On the other hand, we may also suppose that the operations of a centre that has adjusted its opening hours to serve the public outside of normal working hours will be more in line with the community approach than those of a centre that has made no effort of this kind and operates only within the limited range of normal office hours, the usual nine to five.

Operations, management practices and the organization of work are the main operational characteristics of a community centre. They are heavily conditioned not only by ideological considerations (orientations and values) and psychological factors such as staff motivation, but also by level and method of funding.

Funding

Adequate funding, in both quantitative and qualitative terms, is very important for the accomplishment of a community centre's mission. While sufficient, flexible and recurrent funding allows an organization to meet and adapt to community needs, insufficient, rigid and uncertain funding compromises not only the existence of community services but also the quality of programs. There are various methods of funding and the questionnaire included 10 questions aimed at exploring the problem of community centre funding.

The first question dealt with the centre's total budget for 1987-88. It was followed by a question asking for an assessment of the budget's adequacy in relation to the centre's mission.

Questions asking for information on public, private and community sources of funding, as well as on self-financing, enabled us to identify the relative importance of each source. The more an organization relies on self-financing, for example, the greater will be its ability to maintain its independence. It is also significant, in our view, whether a community centre derives part of its revenues from the community. This information also allowed us to determine the relative importance of investment in community health and social services by each level of government – federal, provincial and municipal. Overdependence on a single source of funding may serve to orient a community centre's programs and activities in terms of priorities which are not necessarily local and do not derive from the community.

Community centres often face an uncertain future, especially towards the end of the fiscal year. We therefore asked a question on the recurrent portion of the 1987-1988 budget.

The method of funding – by program, per capita, by number of clients, or global budget – influences strongly a centre's operations.

Some of these funding formulae permit centres greater latitude in defining solutions to problems and identifying responses to needs; thus, global funding and per capita funding seem to us to leave centres a greater margin of independence than funding by specific program or especially by number of clients. The questionnaire also included a question on the method of funding the centres consider most appropriate.

We also wanted to find out whether the centres had been able to introduce innovations during the previous year and especially whether they had succeeded in funding new services or programs.

Finally, we asked a question calling for an assessment of funding bodies' attitudes towards the centres' independence, their orientations, their policies and their programs. This question will afford us a view of the relationships between community centres and funding bodies, based on the centres' perceptions.

A HYPOTHETICAL COMMUNITY CENTRE MODEL

We shall attempt to tie together the above considerations by asking the following question: what is a community centre today, in practical day-to-day terms? There is an abundance of ideological and symbolic discourses on the orientations and sociopolitical importance of the community sector; there are also specific analyses of this or that aspect of the field, such as citizen representation on the Board of Directors, general approach, prevention, etc. We propose as a starting hypothesis that, to be a community centre, an institution must combine a certain number of characteristics at three different levels:

- the level of general orientations (the closest to the ideological or symbolic dimension);
- the level of organization of daily operations (administrative and professional);
- the level of funding (sources, methods).

We are aware that, in reality, there can be no single ideal community centre model given the complexity of the phenomenon, of social situations and of the operations of the organizations, not to mention other external factors such as legal status, funding, etc. We also know that the model we propose is only tentative and subject to refinement, but this need not prevent us from working to clarify the issue and to improve our understanding of this complex, constantly changing field.

In short, then, what is a community centre?

Orientations

The philosophy of community intervention is based on a specific global approach that embraces health and social services and is quite different from a strictly technical approach. This approach is always open to new perspectives and covers a wide range of forms and types of intervention favouring interdependence, solidarity and self-help among the members of a community.

Community intervention is predisposed towards democratic solutions and strongly favours public participation in both the identification of needs and the making of decisions pertaining to services and programs. Various forms of democratic participation are possible: statutory advisory boards, specific decision-making committees connected to the Board of Directors and composed of community members, elections to the Board of Directors (rather than selection or appointment), significant representation for users and the population directly concerned, promotion committees, etc.

In accordance with the ideology of the community approach, users and the public are viewed not as clients or beneficiaries but rather as partners. They are community members with an ability to organize and take control of their lives in increasingly independent ways.

Public authorities and government officials play an ongoing role in developing community-based responses. Territorial communities are always bound, formally and informally, to municipal governments. Governments can support the community movement by defining an overall legal framework for its activities (formal recognition of the community sector as a social actor) and by specifying minimum standards of accessibility and non-discrimination to ensure that services are available to the entire community and that the centres respect the civil and social rights guaranteed in the rights charters. Governments should provide adequate funding but not 100% of the budget, so as to maintain a high level of local and community autonomy.

Operations

The Board of Directors is elected democratically and has statutory powers; otherwise, the centre would belong to the managers and professionals who work there. Board members are elected for a predetermined, limited period (two to three years); the rules for the renewal of their mandates must be made explicit. The Board of Directors deals with real issues and meets frequently enough, at least six times per year.

Ideally, centre staff live in the community. There should be a certain balance between professionals, volunteers and self-educated workers, and the personnel should reflect the composition of the community. The staff is organized into multidisciplinary teams and the basic services offered include preventive programs and collective intervention.

A community centre's goals are legitimized by the community itself. Although procedures and instructions are internal matters, they should favour the community action process. This means that decision-making and appeal procedures are simple, easily accessible, and applied in a flexible way so as to readily adapt to unforeseen situations and changing circumstances.

A community organization is open to cooperation; it seeks to coordinate its activities with other neighborhood resources and to establish stable, on-going partnerships.

Physical and psychological accessibility is an important feature of a community organization. This means adequate, well-located premises, close to mass transit. Opening hours are long enough to allow the public to participate in centre activities. It must be possible to obtain services in the event of an emergency and outside of normal office hours.

Funding

To begin with, a centre needs adequate funding to operate. But the structure and method of funding are also significant: if all funding comes from a single source, this may limit the centre's independence. It is, moreover, logical that a community centre be funded in part by the community.

The funding formula is important: funding by volume of cases is not necessarily the method most conducive to a community approach. Funding by priority programs may diminish a centre's autonomy and reduce the importance of local choices. Global or per capita funding seem to be best suited to the development of community intervention.

The entire data collection process was based on the theoretical framework outlined above. In the next chapter, we shall describe the study's methodology, both in terms of problems encountered, limits and constraints, and in terms of the choices made and the characteristics of our data.

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Chapter 2

METHODOLOGY

The present study has presented a number of methodological problems to which solutions of varying degrees of adequacy have been found. Some of these problems arose from the complexity of the theoretical issues and the difficulty of translating them into operational terms. While these first-level problems were solved, difficulties of a properly methodological nature still remain.

METHODOLOGICAL DIFFICULTIES

Defining the Field

At present, it is practically impossible to establish the number of community health and social service centres in Canada with any degree of certainty. There has never been a systematic inventory of these organizations and even if there had, keeping such a list up to date in every province would represent a major challenge, for the world of local community health and social service intervention is constantly changing. Organizations of this type have varying lifespans, move often, change their names, their missions and their statutes. It is easier to identify traditional health care institutions such as hospitals than to draw up an accurate list of even traditional social services; it is more difficult still to identify community-based organizations.

There is therefore no complete, updated national list. In each province, there are organizations, such as the United Way or Social Planning Council, which keep registers of private non-profit organizations, or of organizations providing personal or collective services. Information and referral centres keep up-to-date lists of public and private resources in the communities they serve. The information is, however, fragmented and often partial; rarely is it complete and up-to-date. This is due to the fact that the organizations that gather the information do so for specific purposes. From that point of view, the information is perfectly adequate. When we wish to examine a phenomenon in its entirety, however, the specialized lists all have gaps which make them difficult to use. For example, of the 1,166 questionnaires sent out, 85 (7.3%) were returned marked unknown at this address or moved.

It is also difficult to agree on the meaning of the term community centre, as it varies from province to province. The situation of the Children's Aid Societies provides a good illustration of this difficulty. In some provinces, they are considered community organizations, for a variety of reasons. They are private, non-profit organizations; they are governed by Boards of Directors whose members come from the community, and they were originally spawned by a community movement.

On the other hand, they provide statutory services defined by a very precise and stringent law, and their work methods are based more on individual than on collective approaches. From a number of points of view, they belong more to the parapublic institutional sector than to the community sector. This does not alter the fact that these organizations can have community workers on staff, or that they may develop certain community-based projects. It is not easy, therefore, to establish uniform criteria by which to identify community centres in all parts of Canada.

Establishing a Sample

If it is practically impossible to delimit the field with any precision, it is also impossible to determine the representativeness of a sample with any certainty. This is a very important limitation for a study of this type, which is not to say that the work is of no interest. On the contrary, the research team believes it is possible to make a contribution to knowledge in this field even if the data has some weaknesses which limits the general conclusions we may draw.

AN EMPIRICAL APPROACH

Given the difficulties inherent in this project, we decided to consult people involved in the community services field or having a good knowledge of community health and social services in each province.

We established a ten-member advisory committee. Owing to financial constraints, we were unable to ensure that every province was represented. We asked our contacts for help in drawing up the list of centres in the following provinces: Prince Edward Island, New Brunswick, Ontario, Manitoba, Saskatchewan and Alberta. In the other provinces, the researchers obtained the assistance of officials in the Department of Health and Social Services, private organizations such as the Social Planning Council or information and referral centres. Using the lists drawn up in consultation with the advisory committee, the research team then called a large number of organizations in each province to confirm their existence, their missions and their services.

Identifying community centres in the social services sector presented special difficulties due to the diversity of operational definitions of social services. When exactly does an act become a social intervention in the technical sense of the term? Can we clearly distinguish between the interventions practiced by multi-service or front-line community centres and those of traditional social service agencies offering what are considered more specialized services?

As is well known, it is often difficult to separate the short term from the long term and the preventive from the therapeutic. Moreover, while the activities of some organizations are relatively easy to classify, due to their status or specific mission (e.g. a rehabilitation centre, a social service agency, a youth centre, a senior citizens club), the activities of many others (especially volunteer organizations) are often broader in scope, ranging from recreation to technical clinical acts. Finally, a clear distinction cannot always be made on the basis of the type of staff: social workers may limit themselves to traditional individual clinical intervention, just as they may make more comprehensive and collective community-type interventions; volunteers sometimes have formal professional training and self-educated workers, though they lack formal professional status, may possess acquired skills and perform professional functions. In any event, we included in this study those centres which met our pre-established criteria.

SELECTING THE CENTRES

To select centres for this study, we began with the general criterion of the centre's mission. The centres chosen had to fall into one of the following categories:

- centres providing general front-line services, preventive or therapeutic, using a community approach (e.g., the Community Health Centres in Ontario);
- centres providing general social services to families or children, using a community approach;
- health or social services centres using a community approach and targeting a particular problem or population:
    - young people
    - women
    - senior citizens
    - the disabled
    - ethnic minorities or immigrants
    - alcoholism and drug addiction
    - mental health; or
- multi-service community centres delivering health and social services based on an integrated approach (e.g., Quebec's CLSCs).

In addition, the centres chosen all had to meet the following three criteria:

- offer direct, formal services;
- be legally incorporated and have as their main mission the provision of health and/or social services in the community; and
- be public or private non-profit organizations.

These criteria guided our choice of the types of organizations to be included and excluded. Thus, organizations whose main mission is to offer residential services, or hospital medical services, or statutory or compulsory services governed by highly prescriptive legislation, were excluded from the study. In the case of the latter category, we concluded that the clients are not voluntary, that the organizations are paragovernmental bodies, and that their institutionalized character does not leave a sufficient margin of autonomy at the local and community level.

In accordance with the requirement that the organizations studied offer direct, formal services, we excluded informal self-help networks and single purpose advocacy groups, for these do not offer a broad range of services.

The legal incorporation requirement eliminated, notably, the community programs of some large organizations which have a broader mission than offering community services (e.g., the community programs of some large psychiatric hospitals). On the basis of this criterion, we also excluded national associations with centralized operations whose local offices are not legally autonomous.

Finally, the significance of these choices must be clarified. The centres selected had to generally match the description in the literature on community services, but this does not mean that some of the organizations excluded might not be community centres, that they might not practice community intervention or incorporate many other community dimensions. Basically, no special significance should be read into the exclusions. It is rather the inclusions that are meaningful: these are the centres that most closely correspond to the research team's conception of community health and social services, based on the literature. The centres chosen in accordance with these criteria do not represent the totality of community health and social service organizations in Canada. The application of these criteria did, however, provide us with an empirical basis for the most accurate possible description of the phenomenon under study.

Of the 1,166 centres selected, 1,115 were considered valid for the purpose of this study, the other 51 were rejected because they were not legally incorporated. Table 2.1 shows the provincial distribution of the centres selected for the study and the number and percentage of the questionnaires received and analyzed (368 questionnaires analyzed out of a potential total of 1,115, for a 33% response rate).

Table 2.1

Percentage of Questionnaires Analyzed

		Questionnaires	
Province	*N*	Received and Analyzed	%
Newfoundland	61	16	26.2
Nova Scotia	87	34	39.1
Prince Edward Island	42	10	23.8
New Brunswick	107	43	40.2
Quebec	155	60	38.7
Ontario	200	49	24.5
Manitoba	120	41	34.2
Saskatchewan	111	44	39.6
Alberta	103	33	32.0
British Columbia	119	37	31.1
	105	367	33.2
Northwest Territories	7	—	—
Yukon	3	1	33.3
Total	**1,115**	**368**	**33.0**

REPRESENTATIVENESS

The study's methodological limitations prevent us from determining the statistical representativeness of the sample. In fact, this work's findings cannot be generalized beyond the 368 centres analyzed. This is a modest figure, but it represents a first step towards a systematic analysis of such community centres across Canada.

Despite this limitation, it is possible to measure the strength of the associations among the model's variables using various statistical techniques.

COLLECTING THE DATA

Our main data collection tool was a questionnaire containing 49 multiple choice questions (cf. Appendix I) divided into four sections:

General Information
Orientations
Operations
Funding

A first draft of this questionnaire was prepared in January 1987 and submitted to ten independent readers for validation. This initial stage allowed us to eliminate the major ambiguities and comprehension problems. The questionnaire was then administered in two stages. In the spring of 1987, it was sent to centres in Quebec and Ontario. The results were presented in an initial report, drafted as part of the research program of the Commission d'enquête sur la santé et les services sociaux du Québec.[1]

After we obtained funding to extend the study to the other provinces, the questionnaire was slightly modified to eliminate some problems of phrasing noted during the analysis of data from the Quebec/Ontario phase of the study. Owing to these modifications, some questions will not be analyzed in the present report.

In addition to mailing 1,166 questionnaires, the research team conducted a total of 70 interviews with government officials, academics, community centre officials, professionals and members of community centre Boards of Directors in all ten provinces.

Having covered theoretical and methodological considerations, we shall now turn to the study's major findings, starting with general characteristics. The main general characteristics are considered determining variables; the correlations among them will be examined in Chapter 3. They will also be cross-tabulated with variables grouped under other headings in the succeeding chapters.

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Chapter 3

GENERAL CHARACTERISTICS

Seven features of the centres under study were examined to arrive at a description of their general characteristics: years of existence, founding body, status, target population, characteristics of the territory served, the population's ethnic homogeneity and the nature of the services offered.

We will begin by presenting the overall data accompanied by a few comments. We will then present and briefly discuss the significant associations found by cross-tabulating these data.

As can be seen from Table 3.1, the creation of community health and social service centres is a relatively recent phenomenon, at least in the population studied. The median number of years of existence is 11, a very low figure for an institutional phenomenon. Forty-nine per cent of the centres have been in existence for between one and 10 years.

Most of the centres (62%) were created by private bodies, volunteer associations or individuals. Where a public body was involved, it was usually a provincial government.

Most of the centres that responded to the questionnaire are private non-profit community organizations (84%).

With respect to clientele, the community centres serve either the entire population of their territories or a specific population or populations (target clienteles; specific age-groups; defined, limited problem-areas, etc.). A slight majority of the centres serve specific populations (54%).

The reliability of the responses concerning the territory served is diminished by the lack of a clear definition in the questionnaire. Two of the categories, urban only and rural only, would appear to be more reliable than the third. If, therefore, we exclude the category which may give rise to confusion,

Table 3.1

General Characteristics

Features	%	*N*	Total
Years of existence			
10 years or less	49	175	
11-20 years	34	121	
21 years or more	17	63	(359)
	100		
Funding body			
Public	14	51	
Private	62	228	
Public and private	24	89	(368)
	100		
Centre's status			
Public community organization	16	59	
Private non-profit community organization	84	307	(366)
	100		
Target population			
Entire population	46	168	
Specific population	54	199	(367)
	100		
Territory served			
Urban only	56	204	
Rural only	16	58	
Urban, semi-urban, rural	28	101	(363)
	100		
Population's ethnic background			
Homogeneous	50	177	
Heterogeneous	50	174	(351)
	100		
Nature of services			
Health care	10	36	
Social services	52	190	
Integrated	38	140	(366)
	100		

mixed and semi-urban environments, we may say that the majority of the centres serve an urban population (56%).

Fifty per cent of the centres serve ethnically homogeneous populations. There is, however, considerable interprovincial variance, as the provincial breakdown presented later will show.

Fifty-two per cent of respondents offer social services only, 38% provide integrated health and social services, and only 10% offer health services exclusively.

Years in Existence

To obtain information on the centres' years of existence, we asked the following question:

"For how many years has the centre been offering health and/or social services?"

The relative youth of the centres has already been noted. The data on years in existence were classified into three categories: 10 years or less, 11 - 20 years, 21 years or more. This breakdown corresponds to the turn of the decades; thus, centres in the first category, those in existence 10 years or less, are products of the 1980-90 period; those in the second category were founded in the 1970s; and those in the third date back to the 1940s, 1950s or 1960s.

Table 3.2 shows years in existence by province. As can be seen, 49% of the centres have been in existence for 10 years or less, 33% for between 11 and 20 years, and only 18% for 21 years or more. The age of the centres shows significant interprovincial variance (p = .000). The Ontario centres are generally the oldest (75% have been in existence for 11 years or more); those in New Brunswick and Saskatchewan are the newest (74% of the New Brunswick centres and 71% of the Saskatchewan centres have been in existence for 10 years or less). If we list the provinces by the age of their community centres, based on the percentage of centres in existence for 11 years or more, we obtain the following order:

Ontario	75%	Nova Scotia	50%
Manitoba	63%	Quebec	48%
Alberta	61%	Newfoundland	44%
Prince Edward Island	60%	Saskatchewan	29%
British Columbia	59%	New Brunswick	26%

Table 3.2

Years in Existence by Province

	10 YRS OR -		11 - 20 YR		21 YRS OR +		TOTAL	
Province	**%**	***N***	**%**	***N***	**%**	***N***	**%**	***N***
Newfoundland	56	(9)	31	(5)	13	(2)	4	(16)
Nova Scotia	50	(17)	27	(9)	23	(8)	10	(34)
Prince Edward Island	40	(4)	40	(4)	20	(2)	13	(10)
New Brunswick	74	(29)	15	(6)	11	(4)	11	(39)
Quebec	52	(31)	43	(26)	5	(3)	17	(60)
Ontario	25	(12)	47	(22)	28	(13)	13	(47)
Manitoba	37	(15)	38	(15)	25	(10)	11	(40)
Saskatchewan	71	(31)	18	(8)	11	(5)	12	(44)
Alberta	39	(12)	29	(9)	32	(10)	9	(31)
British Columbia	41	(15)	43	(16)	16	(6)	10	(37)
Total	**49**	**(175)**	**33**	**(120)**	**18**	**(63)**	**100**	**(358)**

p = .000; Cramer's V* = .26

* Cramer's V: slightly modified version of Phi for tables with more than two rows and two columns

If we organize centres according to the country's four major regions, we find that the centres in Quebec and the Atlantic provinces are generally of more recent origin than those in the other regions. Only 5% of the Quebec centres have been in existence for 21 years or more (see Table 3.3).

It was found that the newer centres are slightly more likely to define their mission in terms of specific populations rather than in terms of the entire population of their territory. The longer a centre has been in existence, the more likely it is to target the entire population of its territory: this is the case with 55% of the centres that have been in existence for 21 years or more, compared with 50% of the centres in the 11 - 20 years category and only 38% of the centres in the 10 years or less category (see Table 3.4).

Table 3.3

Years in Existence by Region

	10 yrs or -		11-20 yrs		21 yrs or +		Total	
Region	**%**	***N***	**%**	***N***	**%**	***N***	**%**	***N***
Atlantic	60	(59)	24	(24)	16	(16)	28	(99)
Quebec	52	(31)	43	(26)	5	(3)	17	(60)
Ontario	25	(12)	47	(22)	28	(13)	13	(47)
West	48	(73)	32	(48)	20	(31)	42	(152)
Total	**49**	**(175)**	**33**	**(120)**	**18**	**(63)**	**100**	**(358)**

p = .000, Cramer's V = .18

If this reflects the trend among community centres as a whole, does this mean that selective approaches are supplanting more global and universal approaches? If the newer centres are targeting specific categories of clients and specializing their missions rather than tackling a territorial community's social and health problems in their entirety, does this indicate a desire for increased efficiency in intervention? Could this be related to the financial policies of the funding bodies? We believe that the trend derives rather from the private status of most of the centres studied. Private community centres more readily reflect the interests of the groups backing them than do public organizations.

Table 3.4

Target Population versus Centre's Years in Existence

Target population

	Entire pop.		Specific pop.		Total	
Years in existence	**%**	***N***	**%**	***N***	**%**	***N***
10 yrs or less	38	(66)	62	(108)	49	(174)
11-20 yrs	50.4	(61)	49.6	(60)	34	(121)
21 yrs or more	56	(35)	44	(28)	17	(63)
Total	**45**	**(162)**	**55**	**(196)**	**100**	**(358)**

p = .02, Cramer's V = .14

The majority of the centres under study serve urban populations (56.2%); only 15.8% serve rural populations (see Table 3.5).

Of the newest centres, 46% serve urban populations and 20% serve rural populations; among the oldest centres, the proportions are 62% and 6% respectively, while the centres that have been in existence for 11-20 years are still more strongly oriented towards urban populations, with 68% serving city-dwellers and 15% serving rural populations. While the respondents generally tend to serve urban populations, we find that a greater percentage of the centres created during the past decade serve rural populations than those created in the preceding decades. This may indicate an improvement in accessibility.

Table 3.5

Centre's Years in Existence versus Territory Served

	Territory							
	URBAN		RURAL		OTHER (SEMI-URBAN, MIXED)		TOTAL	
Years in existence	%	*N*	%	*N*	%	*N*	%	*N*
10 yrs or less	46	(79)	20	(34)	34	(58)	48	(171)
11-20 yrs	68	(81)	15	(18)	17	(21)	34	(120)
21 yrs or more	62	(39)	6	(4)	32	(20)	18	(63)
Total	**56**	**(199)**	**16**	**(56)**	**28**	**(99)**	**100**	**(354)**

p = .000, Cramer's V = .16

Founding Body

Who is responsible for having created the community centres? To identify the centres' founding bodies, we asked the following question:

"Whose decision was it to create the Centre (several answers are possible)?"

Our intention was to find out whether any level of government was involved in the decision to create the organization or whether the centre was the product of the efforts of volunteer organizations or individuals. For purposes of analysis, we divided responses into three categories: public bodies, private bodies, public and private bodies.

Without making this an absolutely determining factor, we may suppose that the founding body has some effect on a centre's development, especially while the centre is still young, as is the case with most of the ones we studied. Depending on whether the founder is the State, public bodies, volunteer organizations or citizens committees, the community's specific characteristics may be taken into account to a greater or lesser degree, purely in terms of institutional logic and quite apart from the people involved. The greater the role played by community initiative in the creation of a centre, the more likely the centre is to reflect that community's specific features.

Table 3.6 presents the data on founding bodies by province. Significant interprovincial variance can be observed (p = .001). In all provinces (without exception), private bodies were the main initiators of the centres (62% of all cases). In a significant proportion of cases (24%), however, both public and private bodies were involved in the decision to create the centre.

Table 3.6

Founding Body by Province

	PUBLIC		PRIVATE		PUBLIC AND PRIVATE		TOTAL	
Province	**%**	***N***	**%**	***N***	**%**	***N***	**%**	***N***
Newfoundland	12	(2)	75	(12)	13	(2)	4	(16)
Nova Scotia	—	(0)	68	(23)	32	(11)	9	(34)
Prince Edward Island	—	(0)	40	(4)	60	(6)	3	(10)
New Brunswick	12	(5)	63	(27)	26	(11)	12	(43)
Quebec	25	(15)	60	(36)	15	(9)	16	(60)
Ontario	16	(8)	59	(29)	25	(12)	13	(49)
Manitoba	5	(2)	59	(24)	36	(15)	11	(41)
Saskatchewan	27	(12)	46	(20)	27	(12)	12	(44)
Alberta	9	(3)	70	(23)	21	(7)	19	(33)
British Columbia	11	(4)	78	(29)	11	(4)	10	(37)
Total	**14**	**(51)**	**62**	**(227)**	**24**	**(89)**	**100**	**(367)**

p = .001; Cramer's V = .24

Of the public bodies involved in creating the centres, provincial governments have been more active and prominent than the other levels of government. As for private bodies, the efforts of individuals seem to have been more significant than those of volunteer organizations: 32% of the centres were created through individual initiative and 19% by volunteer organizations.

It is in Quebec and Saskatchewan that provincial governments seem to have played the most significant role in the creation of community centres (25% and 27% respectively). These figures reflect the existence of the CLSC network in Quebec and the community-based, but public, home care program in Saskatchewan.

There is a strong correlation between the status of the centres and the nature of the founding body (p = .000). As was to be expected, public bodies have founded mostly public centres (69%), while private bodies have founded almost exclusively private centres (97%).

Table 3.7

Centre's Status versus Founding Body

	CENTRE STATUS					
	PUBLIC		PRIVATE		TOTAL	
Founding body	%	*N*	%	*N*	%	*N*
Public	69	(35)	31	(16)	14	(51)
Private	3	(6)	97	(220)	62	(226)
Public and private	20	(18)	80	(71)	24	(89)
Total	**16**	**(59)**	**84**	**(307)**	**100**	**(366)**

p = .000, Cramer's V = .60

The nature of the founding body influences a centre's community strategy, as can be seen from Table 3.8 (p = .000). Most of the centres founded by public bodies (75%) serve the entire population of a given territory while the centres created by private bodies serve mainly specific target populations (63%).

Table 3.8

Target Population versus Founding Body

	Entire pop.		Specific pop.		Total	
Founding body	**%**	***N***	**%**	***N***	**%**	***N***
Public	75	(38)	25	(13)	14	(51)
Private	37	(85)	63	(143)	62	(228)
Public and private	51	(45)	49	(43)	24	(88)
Total	**46**	**(168)**	**54**	**(199)**	**100**	**(367)**

p = .000, Cramer's V = .26

There is also a significant correlation between the founding body and the nature of the territory in which the centre is located (p = .006). Table 3.9 shows that public bodies have been more active than private bodies in creating centres in rural areas (26% versus 12%), while private bodies have been more prominent in urban settings (62% versus 35%).

Table 3.9

Founding Body versus Territory Served

	Territory							
	Urban		Rural		Other (Semi-urban, mixed)		Total	
Founding body	**%**	***N***	**%**	***N***	**%**	***N***	**%**	***N***
Public	35	(18)	26	(13)	39	(20)	14	(51)
Private	62	(139)	12	(27)	26	(57)	61	(223)
Public and private	53	(47)	20	(18)	27	(24)	25	(89)
Total	**56**	**(204)**	**16**	**(58)**	**28**	**(101)**	**100**	**(363)**

p = .006, Cramer's V = .14

According to Table 3.10, there is a strong correlation between the founding body and the nature of the services offered (p = .000). We find that 58% of the centres created by public bodies offer integrated services (health and social services) compared with 33% of the centres created by private bodies. The latter tend rather to focus on social services (61%).

In short, it would appear that the private sector has played the leading role in the creation of community centres. When a public body is involved, it is usually the province. The founding bodies have exercised a fairly determining influence on the main characteristics of the centres studied.

Table 3.10

Nature of Services versus Founding Body

	HEALTH		SOCIAL		INTEGRATED		TOTAL	
Founding body	**%**	***N***	**%**	***N***	**%**	***N***	**%**	***N***
Public	20	(10)	22	(11)	58	(29)	14	(50)
Private	7	(15)	61	(138)	33	(74)	62	(227)
Public and private	12	(11)	46	(41)	42	(37)	24	(89)
Total	**10**	**(36)**	**52**	**(190)**	**38**	**(140)**	**100**	**(366)**

p = .000, Cramer's V = .20

Public or Private Status

A community centre's status (public or private) is an important factor that affects its orientations and allows us to understand the organization. In order to identify each centre's status, we asked the following question:

"What is the legal status of the Centre as specified in its Charter (e.g., private non-profit, public)?"

As can be seen from Table 3.11, the status of the centres varies significantly from province to province (p = .02), even if the large majority of the centres studied are private non-profit organizations (84%).

Quebec and Saskatchewan would appear to have the highest percentage of public community centres. Four provinces – British Columbia, Manitoba, Alberta and Ontario – have above average percentages of private centres. Indeed,

Table 3.11

Status of Centres by Province

	PUBLIC		PRIVATE NON-PROFIT		TOTAL	
Province	%	*N*	%	*N*	%	*N*
Newfoundland	19	(3)	81	(13)	4	(16)
Nova Scotia	18	(6)	2	(28)	9	(34)
Prince Edward Island	—	(0)	100	(10)	3	(10)
New Brunswick	16	(7)	84	(36)	12	(43)
Quebec	30	(18)	70	(42)	16	(60)
Ontario	12	(6)	88	(43)	13	(49)
Manitoba	8	(3)	92	(36)	11	(39)
Saskatchewan	25	(11)	75	(33)	12	(44)
Alberta	9	(3)	91	(30)	9	(33)
British Columbia	5	(2)	95	(35)	10	(37)
Total	**16**	**(59)**	**84**	**(306)**	**100**	**(365)**

p = .02, Cramer's V = .23

95% of the British Columbia centres are private, which seems to be a reflection of the provincial government's orientations over the past decade.

The centres' status also varies significantly by region (p = .01); Quebec seems to be the most publicly oriented, although we still find more private than public centres in our Quebec sample, as is true also of all regions taken together (Table 3.12).

Table 3.12

Status of Centres by Region

	PUBLIC		PRIVATE NON-PROFIT		TOTAL	
Region	%	*N*	%	*N*	%	*N*
Atlantic	15	(16)	85	(87)	28	(103)
Quebec	30	(18)	70	(42)	16	(60)
Ontario	12	(6)	88	(43)	13	(49)
West	2	(19)	88	(134)	42	(153)
Total	**16**	**(59)**	**84**	**(306)**	**100**	**(365)**

p = .01, Cramer's V = .17

Table 3.13

Target Population versus Centre's Status

Status	Total		Specific pop.		Total	
	%	*N*	%	*N*	%	*N*
Public	83	(49)	17	(10)	16	(59)
Private non-profit	39	(119)	61	(187)	84	(306)
Total	**46**	**(168)**	**54**	**(197)**	**100**	**(365)**

p = .000, Phi* = .32

*Phi is a measure of correlation for tables containing two rows and two columns.

A centre's status influences the way it defines the population it seeks to serve. There is a correlation between public status and a territorial approach (Table 3.13), while private centres favour an approach based on specific target groups (p = .000).

We have already noted that few of the centres studied are located in rural areas (p = .000). A higher percentage of public than private centres (Table 3.14), however, are rural (31% versus 13%); a higher percentage of private non-profit centres than public centres are located in urban areas (62% versus 27%). We also find that most private non-profit centres serve urban populations independently of number of years in existence. In the case of public centres, there seems to be a relationship between number of years in existence and service to rural populations; public centres created over the past

Table 3.14

Status of Centres by Territory

	Territory							
	Urban		Rural		Others (Semi-urban, mixed)		Total	
Status	%	*N*	%	*N*	%	*N*	%	*N*
Public	27	(16)	31	(18)	42	(25)	16	(59)
Private	62	(186)	13	(40)	25	(76)	84	(302)
Total	**56**	**(202)**	**16**	**(58)**	**28**	**(101)**	**100**	**(361)**

p=.000, Cramer's V =.26

20 years are more oriented towards rural and mixed populations than are private centres (table not included).

To sum up, centres offering services to the entire population of a given territory tend to be older, are more likely to be public institutions, are more likely to be located in rural areas, and are more likely to serve ethnically heterogeneous populations (table not included). In most cases, public community centres were created by provincial government agencies, while private community organizations are the result of private initiatives on the part of either individuals or voluntary associations.

In terms of the nature of the services offered by public centres, the trend is towards integrating health and social services, while in private centres social intervention clearly predominates (Table 3.15).

Table 3.15

Nature of Services versus Centre's Status

	HEALTH		SOCIAL		INTEGRATED		TOTAL	
Status of centres	**%**	***N***	**%**	***N***	**%**	***N***	**%**	***N***
Public	24	(14)	14	(8)	62	(36)	16	(58)
Private non-profit	7	(22)	60	(182)	33	(102)	84	(306)
Total	**10**	**(36)**	**52**	**(190)**	**38**	**(138)**	**100**	**(364)**

p = .000, Cramer's V = .35

The nature of services (health, social or integrated) varies significantly between public and private centres (p = .000). Table 3.15 shows that private non-profit organizations mainly offer social services (60%) while most public organizations offer integrated services (62%). Twenty-four per cent of the public centres offer mainly health services compared with only seven per cent of private organizations.

If we divide the nature of the services offered into two categories (Table 3.16), integrated and non-integrated, we find significant variance between the level of integration in public and private centres (p = .000).

The majority of respondents (62%) use approaches in which services are not integrated. Most public organizations (62%), however, use an integrated services approach while relatively few private centres (33%) do so.

Table 3.16

Integration of Services versus Centre's Status

	NON-INTEGRATED		INTEGRATED		TOTAL	
Status	**%**	***N***	**%**	***N***	**%**	***N***
Public	38	(22)	62	(36)	16	(58)
Private non-profit	67	(204)	33	(102)	84	(306)
Total	**62**	**(226)**	**38**	**(138)**	**100**	**(364)**

p=.000, Phi=.22

To sum up, with respect to the status of the centres we observe that public organizations differ from private organizations in a number of ways. Public centres, where they exist, tend to adopt a territorial approach; they are more likely to serve rural populations; they generally favour an approach based on the integration of services.

Territorial Community or Community of Interest

Community health and social service centres may define their service mission either in terms of the entire population of a given territory or in terms of more specific groups such as young people, women or the disabled. To obtain information

Table 3.17

Target Population by Province

	ENTIRE POP.		SPECIFIC POP.		TOTAL	
Province	**%**	***N***	**%**	***N***	**%**	***N***
Newfoundland	19	(3)	81	(13)	4	(16)
Nova Scotia	35	(12)	65	(22)	9	(34)
Prince Edward Island	10	(1)	90	(9)	3	(10)
New Brunswick	56	(24)	44	(19)	12	(43)
Quebec	38	(23)	62	(37)	16	(60)
Ontario	59	(29)	41	(20)	13	(49)
Manitoba	44	(18)	56	(23)	11	(41)
Saskatchewan	63	(27)	37	(16)	12	(43)
Alberta	39	(13)	61	(20)	9	(33)
British Columbia	49	(18)	51	(19)	10	(37)
Total	**46**	**(168)**	**54**	**(198)**	**100**	**(366)**

p = .005, Cramer's V = .25

Table 3.18

Target Population versus Ethnic Composition

Ethnic Composition	Entire pop. %	Entire pop. N	Specific pop. %	Specific pop. N	Total %	Total N
Homogeneous	40	(70)	54	(94)	47	(164)
Heterogeneous	60	(107)	46	(79)	53	(186)
Total	**51**	**(177)**	**49**	**(173)**	**100**	**(350)**

p = .007, Cramer's V = .15

on the centres' strategies in this respect, we asked the following question:

"Does the Centre offer its services to the entire population in its territory, or to one or several specific groups only (one answer only)?"

The type of population targeted by the centres varies significantly by province (p = .005). Most of the centres studied (54%) offer services to specific populations. In some provinces, however, the territorial approach is the most common; this is the case in Saskatchewan, Ontario and New Brunswick (see Table 3.17).

The target populations also vary considerably in terms of homogeneity (p = .007). In Table 3.18, we observe a correlation between a territorial approach and ethnically heterogeneous target populations (60% versus 40% in the case of more homogeneous communities). In addition, approaches targeting specific populations appear to be more common where the population is more homogeneous (54% versus 46%).

The nature of the services offered also varies significantly according to the target population (p = .000) (see Table 3.19). While social services tend to target specific populations (groups displaying particular characteristics or sharing a common problem) (64%), the two other categories of services are usually offered to the entire population within a given territory (69% and 54% respectively).

Table 3.19

Nature of Services versus Target Population

Target population	Health %	Health N	Social %	Social N	Integrated %	Integrated N	Total %	Total N
Entire population	69	(25)	36	(68)	54	(75)	46	(168)
Specific population	31	(11)	64	(121)	46	(65)	54	(197)
Total	**10**	**(36)**	**52**	**(189)**	**38**	**(140)**	**100**	**(365)**

p = .000, Cramer's V = .23

If the nature of the services offered is divided into two categories, integrated and non-integrated, the correlation between the nature of the services and the target population persists (p = .02). Integrated services are generally offered to the entire population while separate health and social services (particularly social services) are more frequently offered to specific populations.

Characteristics of the Territory Served

To identify the nature of the territory served by each centre, we asked the following question:

"Is the Centre operating in an urban, semi-urban or rural area?"

For the reasons mentioned previously, we will retain for purposes of analysis only the categories urban area and rural area. Given the lack of a precise definition of these concepts in the questionnaire, the data are presented with reservations. The type of setting in which the population lives varies significantly by province (p = .04). We see in Table 3.20 that most of the centres studied (56%) serve urban populations and a relatively low percentage (16%) serve exclusively rural populations.

Table 3.20

Territory Served by Province

	Urban		Rural		Other		Total	
Province	%	*N*	%	*N*	%	*N*	%	*N*
Newfoundland	57	(8)	21	(3)	22	(3)	4	(14)
Nova Scotia	50	(16)	22	(7)	28	(9)	9	(32)
Prince Edward Island	70	(7)	—	(0)	30	(3)	3	(10)
New Brunswick	42	(18)	26	(11)	32	(14)	12	(43)
Quebec	58	(35)	12	(7)	30	(18)	17	(60)
Ontario	67	(32)	2	(1)	31	(15)	13	(48)
Manitoba	73	(30)	20	(8)	7	(3)	11	(41)
Saskatchewan	46	(20)	20	(9)	34	(15)	12	(44)
Alberta	64	(21)	18	(6)	18	(6)	9	(33)
British Columbia	46	(17)	16	(6)	38	(14)	10	(37)
Total	**56**	**(204)**	**16**	**(58)**	**28**	**(100)**	**100**	**(362)**

p = .04, Cramer's V = .20

Homogeneity and Heterogeneity of the Population Served

To obtain information on the population's degree of ethnic homogeneity, we asked the following question:

"In terms of ethnic composition, is the population fairly homogeneous or heterogeneous (two or three fairly large groups)?" Significant interprovincial variance was found (p = .000) (see Table 3.21).

We observe that the ethnic homogeneity of the population served is greater in the five eastern provinces – Newfoundland, Nova Scotia, Prince Edward Island, New Brunswick and Quebec – than in Ontario and the four western provinces, which seems to reflect the general ethnic makeup of the provinces.

The majority of the British Columbia centres (78%) serve heterogeneous populations, while this is true of only 11% of the Prince Edward Island centres.

Table 3.21

Ethnic Composition by Province

	Population					
	HOMOGENEOUS		HETEROGENEOUS		TOTAL	
Province	%	*N*	%	*N*	%	*N*
Newfoundland	71	(10)	29	(4)	4	(14)
Nova Scotia	56	(18)	44	(14)	9	(32)
Prince Edward Island	89	(8)	11	(1)	3	(9)
New Brunswick	64	(25)	36	(14)	12	(39)
Quebec	85	(50)	15	(9)	17	(59)
Ontario	40	(18)	60	(27)	13	(45)
Manitoba	33	(13)	67	(26)	11	(39)
Saskatchewan	35	(15)	65	(28)	12	(43)
Alberta	36	(12)	64	(21)	9	(33)
British Columbia	22	(8)	78	(29)	10	(37)
Total	51	(177)	49	(173)	100	(350)

p = .000, Cramer's V = .43

Nature of Services Offered

To identify the nature of the services offered, we asked the following question:

"What are the main services provided by the Centre?

- Health services only
- Social services only
- Health and social services
- Other(s) (specify)"

For purposes of analysis, the services offered were also divided into two categories: integrated services (health and social services) and non-integrated services (health or social services).

The nature of the services offered varies significantly by province (p = .002) (see Table 3.22). A significant interprovincial difference was also found when services were classified as integrated or non-integrated.

The nature of services varies significantly in relation to a number of the centres' characteristics, as we have noted throughout this chapter. We shall not reproduce the correla-

Table 3.22

Nature of Services by Province

Province	HEALTH %	SOCIAL %	INTEGRATED %	TOTAL *N*
Newfoundland	6	38	56	(16)
Nova Scotia	6	62	32	(34)
Prince Edward Island	—	70	30	(10)
New Brunswick	14	60	26	(42)
Quebec	5	43	52	(60)
Ontario	16	53	31	(49)
Manitoba	—	58	42	(40)
Saskatchewan	16	29	55	(44)
Alberta	21	52	27	(33)
British Columbia	5	70	24	(37)

p = .002, Cramer's V = .23

tions here; it will suffice to recall that there are associations between the nature of services and the founding body (p = .000), the public or private status of the centre (p = .000) and the centre's target population (p = .000).

Conclusion

The following observations may be made with respect to the general characteristics of the centres studied:

- *they are relatively new;*
- *they were created primarily as a result of private initiatives, particularly the efforts of citizens acting in an individual capacity;*
- *they are private non-profit organizations;*
- *54% of them serve specific populations;*
- *most of them (56%) serve urban populations; and*
- *52% of respondents offer social services exclusively.*

Analysis of the factors presented previously has revealed a certain number of significant associations:

- *the centres display different profiles according to the province or region in which they are located; two major characteristics vary by province: years in existence (p = .000) and founding body (p = .002). The province is one of the main determinants of the characteristics of the centres studied;*
- *centres offering services to specific populations tend to be of more recent origin; they are mostly private non-profit organizations and deal with urban populations. They mainly serve ethnically homogeneous populations. In addition, centres that target a specific population usually provide social services while those that target an entire territorial population more often provide integrated services; and*
- *most public centres and centres created by public bodies offer integrated services to the entire population of a territory and are more likely than private centres to serve rural populations.*

Chapter 4

SERVICES

In the previous chapter, we used the term nature of services to refer to the fields of intervention of the centres studied (health or social services).

This chapter deals with the types of services offered by the centres. The services that an organization offers to the population – the product of all the resources invested in the centre – constitute its main link to community needs. A full understanding of a community centre's function in the community therefore requires an examination of these services.

Types of Services

Continuing our investigation of the services offered, we asked the following question on the types of services:

"Which of the following services have been offered by the Centre in the last twelve (12) months (to individuals or group users and to the general community)?

- information and referral services regarding health and social laws and services;
- health education (awareness-raising groups, public education campaigns, etc.);
- organizing or participating in public campaigns for social change;
- primary prevention (e.g., prenatal courses, courses in effective parenting or personal development, immunization);
- participation in coalitions or in groups promoting legislative or policy changes in the health or social field;
- setting up and supporting community groups aimed at

improving conditions in the environment (e.g., shelters for battered women, proper housing, tenants' associations);
- establishing self-help groups in the health or social sphere;
- outreach work;
- minor health emergencies;
- psycho-social services (crisis situations);
- psycho-social consultations;
- regular services provided by general practitioners (consultation, treatment, follow-up);
- social reintegration services;
- specialized medical services;
- home care;
- loaning space or equipment to groups for community activities;
- loaning staff; and
- other(s) (specify)."

This is a factual question on the services actually provided during a defined period.

Study of the types and range of services offered is of great importance. A centre's response to community needs should involve a wide range of services encompassing both preventive and therapeutic, individual and collective, personal and structural dimensions. Since however, most of the community centres are of modest size, it cannot be expected that all of them would offer the full range of services.

We can see from Table 4.1 that a significant proportion of the centres studied offer the full range of services listed.

The only exception is specialized medical services, which are offered by only eight per cent of respondents. In the "other services" category, which was ticked off by eight per cent of the centres, we find the following services offered or problems addressed: emergency relief (clothing, food, housing); alcoholism and drug abuse; human rights and legal aid; the environment; day care; child abuse; immigrants; home support; unemployment; prostitution; local economic development; accompanying services; and family vacation camps.

Table 4.1

Services Offered

Types of services	%	*N* [1]
Information and referral	86	316
Health education	65	238
Organizing or participating in campaigns	49	181
Primary prevention	67	245
Participation in coalitions	56	204
Setting up community groups	62	228
Establishing self-help groups	58	214
Outreach	54	196
Minor health emergencies	27	100
Psycho-social services	61	224
Psycho-social consultations	56	204
GP consultations	29	107
Social reintegration services	53	192
Specialized medical services	8	29
Home care	37	137
Loaning space	50	184
Loaning staff	31	113
Other services	8	28

[1] total = 366

The services most frequently offered are, in order:

- information and referral;
- primary prevention;
- health education;
- setting up community groups;
- psycho-social services; and
- establishing self-help groups.

The range of services and the high percentage of centres providing different types of services allow us to state that the centres studied offer a wide selection of services and that they do not confine themselves to individual therapeutic intervention.

Overview

Factorial analysis aimed at grouping the centres on the basis of types of services offered identified five main factors, which explain 51.8% of the variance (see Table 4.2). We interpret them as follows:

Social action (20.5% of the variance)

The first factor is services involving action in and with the community. The four services with the greatest weight may be defined as social action services. The fifth point, "information and referral," has less weight but it may be considered a prerequisite for social action services.

Health promotion (10.7% of the variance)

The second factor consists of variables which are not therapeutic but represent rather prerequisites for intervention: "loaning space" and "loaning staff" being the two variables with the greatest weight in the constitution of this factor. Health education and primary prevention may be considered health promotion activities which should precede secondary and tertiary preventive or therapeutic intervention.

Medical intervention (7.5% of the variance)

The third factor consists clearly of variables associated with therapeutic health care.

Psycho-social intervention (7.2% of the variance)

The fourth factor includes variables associated with more traditional social service functions.

External services (6.0% of the variance)

The fifth factor includes only two variables and is more difficult to interpret. It displays an interesting feature: the variable "home care" contributes strongly to its composition while the variable "outreach" contributes negatively. Various hypotheses may be advanced to explain this configuration. We note first a common element in the two variables: these services are offered outside the centre's walls in the client's own milieu – either at home or in the street. These services differ, however, in terms of their organization. Home care requires detailed organization and scheduling: it is provided to specific individuals at defined times during the week and the staff involved must have a highly structured timetable. On the other hand, workers involved in outreach do not have individually identified clients; they do their work in various settings frequented by their target clientele according to highly variable schedules, for they must reach clients where they are, at the most opportune times.

A factorial analysis with a four-factor limit confirmed the effect of the first four factors identified, namely social action, health promotion, medical intervention and psycho-social intervention. "Home care" and "outreach" have only weak associations with any of the four main factors.

We then isolated the centres which offer all the services included in a given factor and compared them with the centres that do not offer all those services. The following results were obtained:

- 37% of the centres offer the entire range of factor I services (social action, community organizing) while 63% do not offer all these services;
- 10% of the centres offer all the factor II services (health promotion and intervention prerequisites) while 90% do not offer the entire range;
- 6% of the centres offer all the factor III services (medical intervention) while 94% do not offer the entire range;
- 28% of the centres provide all the factor IV services (psychosocial intervention) while 72% do not offer the entire range.

It must be borne in mind that a centre that offers all the services belonging to a given factor is not necessarily limited to this factor and may provide other services as well.

Table 4.2

Factorial Analysis of Services Offered by Community Organizations

Factors	Services	Loading
Social action	1. Participation in coalitions	.798
	2. Organizing or participating in public opinion campaigns	.761
	3.Setting up community groups	.615
	4. Establishing self-help groups	.436
	5. Information and referral	.405
Health promotion	1. Loaning space	.694
	2. Loaning staff	.686
	3. Primary prevention	.624
	4. Health education	.444
Medical intervention	1. Specialized medical services	.726
	2. Minor medical emergencies	.679
	3. Consultation	.665
Psycho-social intervention	1. Psycho-social services	.776
	2. Psycho-social consultations	.702
	3. Social reintegration	.676
External services	1. Home care	.718
	2. Outreach	-.663

Social Action (Factor I)

Centres that offer all the social action services were compared with those that do not, by province, status, and by the nature of the services for which a significant relationship was found (Tables 4.3, 4.4, 4.5).

The lowest percentage of centres offering the entire range of social action services was found in New Brunswick (15.4%) and the highest in Newfoundland (56.3%). In two other provinces, Ontario and British Columbia, centres of this type exceed 50% of respondents.

Private non-profit organizations are more likely to be involved in this field than are public organizations (40% versus 20%).

Table 4.3

Social Action Services by Province

	Centres offering all services		Centres not offering all services		Total
	%	*N*	%	*N*	*N*
Newfoundland	56.3	(9)	43.7	(7)	(16)
Nova Scotia	41.9	(13)	58.1	(18)	(31)
Prince Edward Island	37.5	(3)	62.5	(5)	(8)
New Brunswick	15.4	(6)	84.6	(33)	(39)
Quebec	44.4	(20)	55.6	(25)	(45)
Ontario	51.5	(17)	48.5	(16)	(33)
Manitoba	33.3	(13)	66.7	(26)	(39)
Saskatchewan	23.1	(9)	76.9	(30)	(39)
Alberta	25.0	(8)	75.0	(24)	(32)
British Columbia	51.4	(18)	48.6	(17)	(35)
Total					**(317)**

p = .005, Cramer's V = .27

Table 4.4

Social Action Services versus Centre's Status

	Status				
	PUBLIC		PRIVATE NON-PROFIT		TOTAL
	%	*N*	%	*N*	*N*
Centres offering all services	20.3	(11)	40.4	(106)	(117)
Centres not offering all services	79.7	(43)	59.6	(156)	(199)
Total	**100**	**(54)**	**100**	**(262)**	**(316)**

p = .009

Relatively few community health centres provide the full range of social action services (10%); social service centres and integrated services centres are more likely to do so (38.7% and 40.5% respectively).

Table 4.5

Social Action Services versus Nature of Services

	Nature of Services						
	HEALTH		SOCIAL		INTEGRATED		TOTAL
	%	N	%	N	%	N	N
Centres offering all services	10	(3)	38.5	(60)	40.5	(53)	(116)
Centres not offering all services	90	(27)	61.5	(95)	59.5	(78)	(200)
Total	**100**	**(30)**	**100**	**(155)**	**100**	**(131)**	**(316)**

p = .006, Cramer's V = .18

Health Promotion (Factor II)

Cross-tabulation of centres offering the full range of services classified under factor II (health promotion) with different variables (province, status, target population, nature of services) reveals some strong correlations (Tables 4.6 to 4.9).

Table 4.6

Health Promotion Services by Province

	Centres offering all services		Centres not offering all services		Total
Province	%	N	%	N	N
Newfoundland	8	(1)	92	(13)	(14)
Nova Scotia	7	(2)	93	(28)	(30)
Prince Edward Island	0	(0)	100	(8)	(8)
New Brunswick	5	(2)	95	(36)	(38)
Quebec	25	(10)	75	(30)	(40)
Ontario	27	(10)	73	(27)	(37)
Manitoba	8	(3)	92	(34)	(37)
Saskatchewan	0	(0)	100	(40)	(40)
Alberta	7	(2)	93	(28)	(30)
British Columbia	3	(1)	97	(31)	(32)
Total	10.1	(31)	89.9	(275)	(306)

p = .004, Cramer's V = .32

What we notice here is the small number of centres offering all the services of this type. Only in Quebec and Ontario do a relatively high percentage of the centres studied offer the services classified under this factor.

Public community organizations are more likely to provide factor II services than are private non-profit centres (see Table 4.7).

Table 4.7

Health Promotion Services versus Centre's Status

	Centres offering all services		Centres not offering all services		Total	
	%	*N*	%	*N*	%	*N*
Public organizations	24.5	(13)	75.5	(40)	17.4	(53)
Private non-profit organizations	7.1	(18)	92.9	(234)	89.8	(274)
Total	**17.4**	**(31)**	**82.6**	**(274)**	**100**	**(305)**

p = .004, Phi = .22

Centres serving the entire population of a given territory are more likely to provide the services classified under factor II than are those targeting specific populations (p = .005) (see Table 4.8).

Table 4.8

Health Promotion Services versus Target Population

	Centres offering all services		Centres not offering all services		Total	
Target population	%	*N*	%	*N*	%	*N*
Entire population	16.6	(25)	83.4	(126)	49.3	(151)
Specific population	3.9	(6)	96.1	(149)	50.7	(155)
Total	**10.1**	**(31)**	**89.9**	**(275)**	**100**	**(306)**

p = .005, Phi = .21

Integrated services centres are more likely to offer factor II services than are centres providing only social services or health services (see Table 4.9).

Table 4.9

Health Promotion Services versus Nature of Services

Nature of services	Centres offering all services %	Centres offering all services N	Centres not offering all services %	Centres not offering all services N	Total %	Total N
Health	5.6	(2)	94.4	(34)	11.8	(36)
Social	3.4	(5)	96.6	(142)	48.2	(147)
Integrated	19.7	(24)	80.3	(98)	40.0	(122)
Total	**10.2**	**(31)**	**89.8**	**(274)**	**100**	**(305)**

p = .000, Phi = .26

Medical Services (Factor III)

Only 17 centres offer the full range of factor III services, which we have termed medical services. Cross-tabulation with the main determining variables reveals only two significant correlations.

These services are available in few centres. Most of them are centres offering health services and targeting the entire population of a given territory (tables not included).

Table 4.10

Psycho-social Services by Province

Province	Centres offering all services %	Centres offering all services N	Centres not offering all services %	Centres not offering all services N	Total %	Total N
Newfoundland	33.3	(5)	66.7	(10)	5.2	(15)
Nova Scotia	31.0	(9)	69.0	(20)	10.1	(29)
Prince Edward Island	16.7	(1)	83.3	(5)	2.1	(6)
New Brunswick	5.4	(2)	94.6	(35)	12.8	(37)
Quebec	34.2	(13)	65.8	(25)	13.2	(38)
Ontario	26.9	(7)	73.1	(19)	9.0	(26)
Manitoba	40.5	(15)	59.5	(22)	12.8	(37)
Saskatchewan	13.2	(5)	86.8	(33)	13.2	(38)
Alberta	32.3	(10)	67.7	(21)	10.8	(31)
British Columbia	41.9	(13)	58.1	(18)	10.8	(31)
Total	**27.8**	**(80)**	**72.2**	**(208)**	**100**	**(288)**

p = .01, Cramer's V = .27

Psycho-social Services (Factor IV)

The services classified under this factor are offered by 28% of the centres studied. Interprovincial variance is significant at p = .01 (see Table 4.10).

Table 4.11

Psycho-social Services versus Nature of Services

	Centres offering all services		Centres not offering all services		Total	
Nature of services	%	*N*	%	*N*	%	*N*
Health	7.4	(2)	92.6	(25)	9.4	(27)
Social	28.2	(40)	71.8	(102)	49.5	(142)
Integrated	31.3	(37)	68.7	(81)	41.1	(118)
Total	**27.5**	**(79)**	**72.5**	**(206)**	**100**	**(287)**

p = .04, Phi = .15

As was to be expected, psycho-social services are most commonly found in social service and integrated services centres (Table 4.11).

The data presented in this chapter indicate that the centres studied offer a wider range of social services than health services. They are more likely to offer comprehensive front-line services, support services, self-help, community organizing and social action services than therapeutic, specialized or institutional services. Private non-profit centres and those with a social services mission are more involved in community organizing and social action than are public centres or those that deliver health care.

Chapter 5

HUMAN RESOURCES

A service-providing organization's human resources are one of the main determinants affecting both the relevance and the quality of the services offered. A community centre may be expected to hire staff capable of practicing global intervention and trained in collective intervention. In addition, the centre's openness to the community should lead it to use personnel who are from the community (competent self-educated workers, volunteers) and reflect its ethnic composition.

Size of Staff

As can be seen from Table 5.1, the centres have relatively few staff positions. The 365 respondents indicated they have a total of 8,943 salaried positions in all categories, for an average of 24.5 positions per centre. Interprovincial variance is significant at 0.04. In three provinces – British Columbia, Ontario and Quebec – average staff size is well above the national average, while in the four Atlantic provinces and Saskatchewan average staff size is well below the national average.

The average number of positions in a centre also varies according to the nature of the services offered ($p = .000$) (see Table 5.2). Centres offering integrated services generally have more staff than centres providing health or social services only. In every province, we find that the centres offering social services exclusively have the smallest average number of employees.

Table 5.1

Total and Average Number of Staff Positions by Province

PROVINCE	NUMBER OF CENTRES	POSITIONS N	POSITIONS AVERAGE
Newfoundland	16	137	8.6
Nova Scotia	34	521	15.3
Prince Edward Island	10	63	6.3
New Brunswick	42	705	16.7
Quebec	60	1,786	29.8
Ontario	49	1,727	35.2
Manitoba	40	992	24.8
Saskatchewan	44	698	15.9
Alberta	33	843	25.5
British Columbia	37	1,471	39.8
Total	**365**	**8,943**	**24.5**

Table 5.2

Total and Average Number of Staff Positions versus Nature of Services

NATURE OF SERVICES	NUMBER OF CENTRES	POSITIONS N	POSITIONS AVERAGE
Health	36	1,008	(28.0)
Social	190	2,800	(14.7)
Integrated	139	5,135	(36.9)
Total	**365**	**8,943**	**(24.5)**

p = .000

When we cross-tabulate staff size and the centre's status (Table 5.3), we find a significant difference between private and public centres (p = .004).

Public organizations have an average of 38.9 positions while private non-profit organizations have 21.5 positions. More detailed analysis of the data shows, however, that in some provinces – Newfoundland, New Brunswick, Ontario and Manitoba – private non-profit organizations have slightly more employees than do public organizations.

Table 5.3

Total and Average Number of Staff Positions versus Centre's Status

Status	Number of centres	Positions *N*	Positions Average
Public	59	2,298	(38.9)
Private non-profit	306	6,589	(21.5)
Total	**365**	**8,887**	**(24.3)**

p = .004

Finally, the average size of staff varies significantly between centres serving the entire population of a given territory and those serving specific populations (p = .000) (see Table 5.4).

Table 5.4

Total and Average Number of Staff Positions versus Target Population

Target population	Number of centres	Positions *N*	Positions Average
Entire population	168	5,989	35.6
Specific population	198	2,954	14.9
Total	**366**	**8,943**	**24.4**

p = .000

Centres that indicated they serve the entire population of their territory have an average of 35.6 employees compared with 14.9 for those targeting specific populations. This is not surprising: it is to be expected that, given their comprehensive nature, organizations serving the entire population of a territory would offer a wider range of services. They consequently need a larger number of employees.

To sum up, the number of employees in the centres studied varies significantly according to the province, the nature of services, the centre's status and the target population. The centres with the most employees are generally in the most populous and urbanized provinces (Ontario, Quebec, British Columbia); they tend to be integrated services centres and to offer services to the entire population of their territories.

Type of Personnel

Community centres employ various types of salaried personnel to accomplish their missions. In this section, we analyze staff breakdowns in relation to whether the centre offers health services, social services or integrated services.

The 36 centres with an exclusive health care vocation (see Table 5.5) employ primarily nurses (40%), doctors (8%) and other health care professionals (8%). They have few community workers or social workers.

Table 5.5

Personnel in the 36 Community Health Centres

	Positions		
CATEGORIES	*N*	AVERAGE	%
Nurses	406	11.3	40.2
Doctors	77	2.1	8.0
Other health care professionals	80	2.2	8.0
Health care technicians	39	1.1	4.0
Self-educated health workers	32	0.9	3.2
Community workers	39	1.1	4.0
Clinical social workers	25	0.7	3.0
Administrative and support staff	165	4.6	16.0
Others	145	4.0	14.0
Total	**1,008**	**28.0**	**100**

The centres with an exclusive social service vocation employ primarily professionals in the social sciences (see Table 5.6).

Self-educated workers represent the largest single category of staff in community social service centres. We also note that health care workers are a fringe category in these centres (1.9%).

Integrated health and social services centres have more diversified and better balanced staff than those with exclusive missions (see Table 5.7). We see that each category represents at least six per cent of staff. Nurses constitute the largest category of employees in these comprehensive centres (16%), followed by community workers (10%) and social workers (9%).

Table 5.6

Personnel in the 183 Community Social Service Centres			
	Positions		
Category	N	Average	%
Clinical social workers (university trained or technicians)	465	2.5	16.8
Community workers (university trained or technicians)	355	2.0	12.9
Other social science professionals	286	1.6	10.4
Self-educated social service workers	571	3.1	20.7
Health care workers (all categories)	53	0.3	1.9
Administrative and support staff	557	3.0	20.2
Others	473	2.6	17.1
Total	2,760	15.1	100

Table 5.7

Personnel in the 135 Comprehensive Community Centres			
	Positions		
Category	N	Average	%
Nurses	766	5.7	15.6
Community workers (university trained or technicians)	477	3.5	9.7
Clinical social workers (university trained or technicians)	458	3.4	9.3
Self-educated workers (health and social)	385	2.9	7.9
Doctors	274	2.0	5.6
Other categories of health care workers	406	3.0	8.3
Other social science professionals	329	2.4	6.7
Administrative and support staff	866	6.4	17.7
Other categories of paid employees	942	7.0	19.2
Total	4,903	36.3	100

If we now classify all service-providing positions into two categories, health intervention and social intervention (see Table 5.8), we find that the average number of health intervention positions is slightly lower than the average number of social intervention positions at 6.7 versus 8.9. There are some exceptions, however: in Saskatchewan, Ontario, Quebec and Newfoundland, health care personnel are proportionately slightly more numerous.

Table 5.8

Total and Average Number of Health and Social Service Positions by Province

	SERVICES					
	HEALTH		SOCIAL		TOTAL	
PROVINCE	*N*	AVERAGE	*N*	AVERAGE	*N*	AVERAGE
Newfoundland	55	3.4	45	2.8	100	6.3
Nova Scotia	101	2.9	293	8.6	394	11.6
Prince Edward Island	18	1.8	31	3.1	49	4.9
New Brunswick	208	4.8	372	8.6	580	13.5
Quebec	555	9.2	469	7.8	1,024	17.1
Ontario	608	12.4	515	10.5	1,123	22.9
Manitoba	159	4.1	517	13.2	732	18.8
Saskatchewan	290	6.5	113	2.6	403	9.2
Alberta	271	8.2	388	11.7	659	19.9
British Columbia	175	4.7	526	14.2	701	18.9
Total	**2,440**	**6.7**	**3,268**	**8.9**	**5,709**	**15.6**

Interprovincial variance in health care positions: not significant

Interprovincial variance in social service positions: p = .03

Examination of these two staff categories in relation to the centre's status and the nature of services reveals some significant correlations. The average number of health care positions is much higher in public centres than in private nonprofit centres at 18.1 versus 4.5 (p = .000). With respect to social intervention positions, however, the gap between public and private centres is not significant.

The average number of medical positions and social service positions varies significantly according to the nature of services (p = .000 and .03 respectively). As might be expected, we find more medical positions in centres offering health care

Table 5.9

Total and Average Number of Intervention Positions and Administrative and Support Positions by Province

	Intervention		Administration and Support		
Province	*N*	Average	*N*	Average	Ratio
Newfoundland	110	6.9	27	1.7	4.1
Nova Scotia	408	12.0	113	3.3	3.6
Prince Edward Island	49	4.9	14	1.4	3.5
New Brunswick	585	13.6	120	2.8	4.9
Quebec	1,392	23.2	394	6.6	3.5
Ontario	1,422	29.0	305	6.2	4.7
Manitoba	743	18.1	257	6.3	2.9
Saskatchewan	589	13.4	109	2.5	5.4
Alberta	688	20.8	155	4.7	4.4
British Columbia	1,271	34.3	200	5.4	6.4
Total	**7,257**	**19.8**	**1,694**	**4.6**	**4.3**

p = .038

and more social service positions in centres offering social services. In integrated services centres, there are about equal numbers of positions in the two categories (12.8 health care positions versus 10.3 social service positions).

The community centres studied devote the greatest portion of their salaried human resources to intervention. They have minimal administrative and support structures (see Table 5.9).

Overall, there are 4.3 intervention positions for every administrative or support position. Interprovincial variance in this ratio is significant at p = .04. British Columbia has the lowest ratio of administrative and support staff to intervention staff at 1:6.4, Manitoba the highest at 1:2.9. The average number of administrative and support positions is significantly higher in public centres (8.6) than in private non-profit centres (3.8) (p = .000).

Table 5.10

Total and Average Number of Paid and Unpaid Positions by Province

	PAID POSITIONS		UNPAID POSITIONS (VOLUNTEERS)		
PROVINCE	*N*	AVERAGE	*N*	AVERAGE	RATIO
Newfoundland	137	8.6	241	15.1	1.8
Nova Scotia	521	15.3	1,057	31.1	2.0
Prince Edward Island	63	6.3	155	15.5	2.5
New Brunswick	705	16.4	935	21.7	1.3
Quebec	1,786	29.8	1,837	31.4	1.1
Ontario	1,727	35.2	1,314	26.8	0.8
Manitoba	1,000	24.4	1,198	29.2	1.2
Saskatchewan	698	15.9	1,989	45.2	2.9
Alberta	843	25.5	3,349	101.4	4.0
British Columbia	1,471	39.8	1,939	52.4	1.3
Total	8,951	(36.7)	14,064	(36.7)	1.6

Average number of paid positions for all centres: 24.4
Average number of unpaid positions for all centres: 38.3

The human resources of the centres studied do not consist solely of paid staff. The research team gathered information on the number of volunteers, not counting Board members, who provide community services or are involved directly in community activities developed under the centre's aegis.

The organizations that participated in this study have considerably more volunteers than paid employees. The overall average for all the centres is 24.4 paid positions and 38.3 volunteers per centre, or 1.6 volunteers for every paid employee (see Table 5.10). The ratio is lowest in Ontario, at 0.8; it rises to 4 in Alberta. Interprovincial variance in the average number of volunteers per centre is significant at p = .002.

Analysis of the number of positions filled by volunteers in relation to the nature of services reveals no significant correlations in the centres studied taken as whole. If, however, we look at the ratio of unpaid positions to paid positions, we find that community social service centres (with a ratio of 2.6:1) seem to make more extensive use of volunteers than do health

Table 5.11

Ratio of Average Number of Volunteers to Average Number of Paid Positions versus Nature of Services

NATURE OF SERVICES	VOLUNTEERS AVERAGE	PAID POSITIONS AVERAGE	RATIO
Health	26.0	28.0	0.9
Social	38.5	14.7	2.6
Integrated	41.1	36.6	1.1

care centres (0.9:1) or integrated services centres (1.1:1) (see Table 5.11).

Both public and private non-profit centres make use of volunteers but there is a large difference in the ratios: the ratio of volunteers to paid employees is three times higher in private non-profit centres than in public centres (Table 5.12).

To sum up, community health and social service centres make fairly extensive use of volunteers in the performance of their missions. In some provinces, particularly Alberta, the use of volunteers seems to be more developed. We also found a greater tendency to use volunteers in community social service centres and in private non-profit organizations.

Table 5.12

Ratio of Average Number of Volunteers to Paid Positions by Centre's Status

STATUS	VOLUNTEERS	PAID POSITIONS	RATIO
Public	24.0	38.9	0.62
Private non-profit	41.1	21.5	1.91

Sensitivity to Minority Ethnic Groups

In the case of centres serving ethnically heterogeneous populations, it is worth considering whether their staff is capable of serving minority ethnic groups. We may also ask whether the centre has members of minority groups among its employees.

Analysis of the data on this subject shows a strong correlation (p = .000) between the presence of ethnic staff in a centre and the ethnic composition of the target population – homogeneous or heterogeneous (table not included). Moreover, among the centres serving heterogeneous populations, 133 or 51.2% report that their staff can serve minority ethnic groups in their own language, while 48.8% cannot do so. Almost sixty per cent of the centres have one or more members of minority ethnic groups among their paid employees.

Organization of Work

The last part of our analysis of the centres' human resources deals with the organization of work. How do the centres organize their employees' tasks? Do employees work in teams or do they perform individual tasks? If they work in teams, are these teams uni- or multidisciplinary?

In response to this question, the majority of centres (66%) reported that at least part of their staff is organized into intervention teams, while 34% have no such teams. Half of the centres with teams (50%) have both single and multidisciplinary teams, one third (33%) have only multidisciplinary teams and just 13% have only single-discipline teams.

Of the centres that have no teams, the great majority (74%) say the reason is limited staff.

There is a correlation between organization into teams and target population (p = .04), and between teams and type of territory served (p = .002). We find that the majority of centres that serve entire territorial populations (63%) have chosen to organize their employees into teams, compared with 50% of the centres serving specific groups. Urban centres also favour team organization.

It would appear that centres that are able to work with teams because they have enough employees to do so readily opt for this form of organization, and this is most likely to be the case with urban centres and those that offer services to the entire population of their territory.

Chapter 6

ACCESSIBILITY

In the case of any service, it is important that it be easily accessible. In the field of community services, accessibility is part of the very definition of the intervention. We asked a series of six questions to obtain information on various aspects of a centre's physical accessibility:

1) daily opening hours (times and total number of hours);
2) availability of emergency service; and
3) location of equipment and means of communications.

INDICATORS OF ACCESSIBILITY

Daily Opening Hours (Times and Total Number of Hours)

We asked respondents to indicate whether their centre is open seven days a week or only on some days (e.g., Monday through Friday). We also asked them to indicate their opening hours, which can vary from a few hours to 24 hours a day, and be offered at different times of the day, such as morning or evening. This question is related to the centre's mission, its setting, the other resources available in the community, and community needs. It is also conditioned, however, by budget and staff limitations. Opening hours alone provide an incomplete measure of a centre's accessibility, but it must be admitted that a centre which is open 24 hours a day, seven days a week, is more accessible than a centre which is open only some hours of the day, a few days a week.

Emergency Service

We also used as an indicator of accessibility the availability of emergency service when the centre is not in operation, or at least the possibility of easily reaching service-providers outside of opening hours if need be. While the existence of such service is also only a partial indicator, it does suggest accessibility and responsiveness to community needs in the case of centres providing services in fields where emergency situations arise.

Location of Facilities and Availability of Communication

Finally, an accessible centre must be well located, close to most of its clients and to the centre of the community. It should be easy to reach by major means of transportation, whether it be mass transit in urban areas or individual private transportation in rural areas. The centre should also be equipped with modern means of communication (telephone, radio, etc.) for the purpose of informing the public and communicating with the community.

Table 6.1 presents the most significant data concerning the accessibility of the centres. We see notably that 25% of the centres studied are open seven days a week and 32% are open at different times of the day, facilitating access for people who work or cannot get to the centre during the day. Slightly over one third of the centres (37%) offer emergency services. With respect to location and availability of communication, most of the centres believe that their service points are well located (83%), that there are adequate means of transportation for reaching the centre (68%) and adequate means of communication with the public (88%).

Table 6.1

Access to Centres

ACCESSIBILITY	*N*	%
Open seven days		
Yes	89	25
No	268	75
Total	(357)	100
Opening hours		
Mornings or afternoons only	8	2
Mornings and afternoons	233	66
Mornings, afternoons and evenings, or 24 hours	112	32
Total	(353)	100
Emergency service		
Yes	134	37
No	153	42
N/A	78	21
Total	(365)	100
Location		
Adequate	303	83
Fairly adequate	53	15
Inadequate	8	2
Total	(364)	100
Availability of transportation		
Adequate	243	68
Fairly adequate	73	20
Inadequate	44	12
Total	(360)	100
Availability of communication		
Adequate	321	88
Fairly adequate	37	10
Inadequate	6	2
Total	(364)	100

GENERAL ACCESSIBILITY

In order to assess the general accessibility of the centres, we constructed an index based on the six questions (see following page). Table 6.2 shows how the centres rate in terms of degree of accessibility.

Table 6.2

Community Centres' Degree of General Accessibility

GENERAL ACCESSIBILITY	N	%
High	42	12
Medium	205	59
Low	98	28
Total	**368**	**100**

Index average:	12.5
Median:	12.0
Minimum score:	6
Maximum score:	18

The majority of the centres received a medium accessibility rating (59%), less than a third received a low rating (28%), and quite a small proportion a high rating (12%).

A significant correlation was found between accessibility and the centre's status (p = .002). It would appear that private non-profit centres are more accessible than public centres (p = .002): three-quarters of them earned a medium or high general accessibility rating, compared with 55% of public centres. This finding is no doubt related to the fact that the private organizations are more often found in urban areas. As a greater proportion of public centres serve rural or mixed areas, we may assume that they would be more difficult to reach (see Table 6.3).

Accessibility Index

VARIABLE	VALUE
Open 7 days/week	Yes - 3
	No - 1
Opening hours	Mornings only - 1
	Afternoons only - 1
	Mornings and afternoons - 2
	Mornings, afternoons and evenings/nights - 3
	24 hours - 3
Emergency service	Yes - 3
	No - 1
	N/A - average of replies
Location	Adequate - 3
	Fairly adequate - 2
	Inadequate - 1
Availability of transportation	Adequate - 3
	Fairly adequate - 2
	Inadequate - 1
Availability of communication	Adequate - 3
	Fairly adequate - 2
	Inadequate - 1
Maximum score	18
Minimum score	6
3 degrees of accessibility	16 - 18: high
	12 - 15: medium
	6 - 11: low

(Recoded with an average of 13.5 and a standard deviation of 1.6)

Resulting scores appear in Table 6.2

Table 6.3

Degree of General Accessibility versus Centre's Status

STATUS	Degree of general accessibility LOW %	 MEDIUM %	 HIGH %	TOTAL
Public	46	51	4	(57)
Private non-profit	25	62	13	(286)
Total				**(343)**

p = .002, Cramer's V = .19

There is also a correlation between degree of accessibility and type of territory: urban areas appear to be the best served in terms of access. We find a much higher percentage of centres with a medium accessibility rating in urban areas than in rural areas (68% versus 38%). The percentage of centres with high ratings is fairly similar and rather low in all types of territory (see Table 6.4).

Table 6.4

Degree of General Accessibility versus Territory Served

TERRITORY	Degree of general accessibility LOW %	 MEDIUM %	 HIGH %	TOTAL
Urban	20	68	12	(191)
Rural	49	38	13	(53)
Other (semi-urban or mixed)	32	54	14	(42)
Total				**(340)**

p = .000, Cramer's V = .17

To sum up, the centres studied are encountering some difficulty making their services fully accessible, as can be seen by the small percentage that scored in the "high general accessibility" category (12%). Private non-profit organizations and those serving urban populations tend to rate higher in this area.

Chapter 7

PUBLIC PARTICIPATION

Public participation in the management of organizations that have a direct effect on citizens' living conditions is an important element of local democracy. It is also a basic element of community intervention. When we hear the word participation, we naturally think of participation in the general management of a centre through its Board of Directors. This is indeed basic, but it is not the only factor nor perhaps the most important one: there is also the question of public participation in identifying needs and orienting programs, which can be achieved through a variety of mechanisms and implies active cooperation and partnership between community workers and community members.

The greater the provision for democratic participatory mechanisms, the more likely it is that a centre will be sensitive to the community and the more faithful the centre is to the community approach.

In this chapter, we shall analyze three questions:

- participation in the identification and analysis of needs;
- participation in decision making concerning projects, programs and services; and
- the composition of the Board of Directors and its operating methods.

PARTICIPATION IN THE IDENTIFICATION AND ANALYSIS OF NEEDS

Citizen participation in the identification of community needs can be more or less active. Some mechanisms permit relatively passive participation, such as answering survey questions or participating in studies. Other mechanisms—such as user advisory boards or citizens committees—provide for consultation; these consultation mechanisms make it possible to obtain the opinions of those consulted, but decision-making power remains in the hands of the mandated administrative or professional bodies.

Other mechanisms which are more directly connected to the Board of Directors, such as statutory committees composed of Board members, involve decision-making powers.

The questionnaire asked centres to indicate whether citizens participate in identifying needs. If so, they were asked to specify the type of mechanism used. Table 7.1 shows the results obtained.

Table 7.1

Participation in Identification of Needs

PARTICIPATION	*N*	%	TOTAL
Participation in identification of needs	305	85	(361)
Citizens or users elected to Board of Directors	244	82	(296)
Surveys conducted in community	210	75	(282)
Association representatives elected to Board of Directors	152	54	(281)
Representatives of the municipality on the Board of Directors	85	31	(278)
Other means	57	29	(194)

We find that a high percentage of the centres provide for participation in the identification of needs (85%). Of the most common methods, the election of citizens or users to the Board of Directors is the most popular, followed by surveys and the election of association representatives to the Board of Directors.

Only one third of the centres call upon representatives of the municipality to help in identifying local needs.

PARTICIPATION IN DECISION MAKING

The other indicator of participation relates to decision making. Participation in decision making implies more direct power over a centre's orientations and management than is permitted by participation in the identification of needs alone. Table 7.2 presents the data concerning participation in decision making: such participation was reported by a smaller percentage of centres than participation in identifying needs (72% versus 85%).

Table 7.2

Participation in Decision making

	N	%	TOTAL
Participation	265	72	(368)
Citizens or users elected to Board of Directors	212	84	(252)
Association representatives elected to Board of Directors	122	51	(241)
Decision-making committees including citizens	151	63	(241)
Representatives of the municipality on the Board of Directors	68	29	(236)
Other means	34	20	(171)

Participation in decision making is most often achieved through the election of citizens to the Board of Directors (84%) and representation on decision-making committees (63%). On the whole, the centres are more likely to provide for participation in the identification of needs, which is more limited and less determining; where they do provide for participation in decision making, the means chosen seem to be less diverse.

Overall participation

In order to obtain an overview of participation in the functioning of the centres, we constructed an index which takes into account the type of participation (identification of needs and/or decision making) and the number of mechanisms used to promote such participation.

The results of the two indices were combined to obtain a measurement of participation. The minimum score on the scale is 0 and the maximum is 20. Three levels of participation were defined on the basis of the average and the standard deviation:

low participation: 0 to 5 points
medium participation: 6 to 16 points
high participation: 17 to 20 points

Index of Participation in the Identification of Needs

Variables	Weight
Participation in the identification of needs	Yes - 5 No - 0
If yes, Citizens elected to the Board of Directors	Yes - 1 No - 0
Representatives of volunteer associations on the Board of Directors	Yes - 1 No - 0
Representatives of the municipality on the Board of Directors	Yes - 1 No - 0
Surveys conducted in the community	Yes - 1 No - 0
Other mechanisms	Yes - 1 No - 0

Maximum score - 10; minimum score - 0

Index of Participation in Decision making

VARIABLES	WEIGHT
Participation in decision making	Yes - 5
	No - 0
If yes,	
Citizens elected to the Board of Directors	Yes - 1
	No - 0
Representatives of volunteer associations on the Board of Directors	Yes - 1
	No - 0
Representatives of the municipality on the Board of Directors	Yes - 1
	No - 0
Decision-making committees	Yes - 1
	No - 0
Other mechanisms	Yes - 1
	No - 0

Maximum score - 10; minimum score - 0

The following table presents the distribution of scores obtained on this index.

Table 7.3

Overall Participation in the Life of the Centre

OVERALL PARTICIPATION	*N*	%
High	30	13
Medium	156	69
Low	41	18
Total	**227**	**100**
Index average	10.7	
Median	13.0	
Minimum score	0.0	
Maximum score	20.0	

A relatively low percentage of centres (13%) obtained a high rating by promoting both types of participation and/or by using a number of mechanisms. The majority of the centres (69%) ranked in the medium category, and it would appear from the previous tables that the preferred method is the election of citizens to the Board of Directors.

When we look at level of participation in the functioning of the centres by province (see Table 7.4), we find significant variance (p = .03).

While these results must be interpreted with caution given the small number of respondents in some provinces, the fact that none of the centres in Newfoundland, Nova Scotia or Prince Edward Island ranked in the high participation category suggests some shortcomings in this area. Manitoba seems to have the most highly developed mechanisms for citizen participation.

Table 7.4

Overall Participation by Province

	OVERALL PARTICIPATION			
PROVINCE	LOW %	MEDIUM %	HIGH %	TOTAL
Newfoundland	50	50	—	(4)
Nova Scotia	60	40	—	(10)
Prince Edward Island	50	50	—	(2)
New Brunswick	36	46	18	(11)
Quebec	14	79	7	(57)
Ontario	19	64	17	(42)
Manitoba	6	72	22	(32)
Saskatchewan	13	87	—	(8)
Alberta	13	77	10	(31)
British Columbia	17	63	20	(30)
Total				**(227)**

p = .0259, Cramer's V = .26

The only other significant correlation found was between the degree of participation and the centre's target population (see Table 7.5).

Table 7.5

Overall Participation versus Target Population

	OVERALL PARTICIPATION			
Target population	LOW %	MEDIUM %	HIGH %	TOTAL *(N)*
Total population	11	74	15	(101)
Specific population	24	64	12	(126)
Total				**(227)**

p = .041, Cramer's V = .17

The level of participation is slightly higher in centres serving the entire population of a territory than in those serving specific populations.

To sum up, we assumed that the centres would provide for mechanisms to allow for participation in the identification of needs and/or decision making. It was found that the preferred mechanism, by far, is the election of citizens to the Board of Directors. As for mechanisms other than those we listed, they were found to be not very diverse; few centres reported other forms of participation. Finally, we find that the level of participation in the life of community centres varies significantly from province to province.

COMPOSITION AND OPERATION OF THE BOARD OF DIRECTORS

The election of community members to the Board of Directors or to committees is not the only possible form of active public participation. Such participation can also be achieved through the direct involvement of volunteers in the centre's programs and activities. We shall not return here to the important contribution made by volunteers, which has already been noted in Chapter 5.

Another very important indication of a centre's degree of democracy is the composition and mode of operation of the Board of Directors. The number of members, their status, the way they are recruited, the way their terms are renewed, the

Board's operating practices (e.g., number of meetings per year, terms of office) are all factors which reflect in practical terms a centre's community approach.

Table 7.6

Composition of Board of Directors

NUMBER OF MEMBERS	NUMBER OF CENTRES	%
7 or fewer	51	15
8 - 19	241	70
20 or more	51	15
Total	**(343)**	**100**
Average number of members	13.3	
Mode	12.0	
Median	12.0	
Standard deviation	5.8	

COMPOSITION OF BOARD OF DIRECTORS

The Boards of Directors of the centres studied have an average of 13.3 members (see Table 7.6).

The majority of the Boards (70%) have between 8 and 19 members; 15% of the centres have very small Boards (7 members or fewer) and an equal percentage have very large Boards (20 members or more).

We may assume that having very few members would create certain problems in terms of the Board's representativeness; on the other hand, too many members can slow or even paralyze the Board's operations.

Table 7.7 presents the total and average numbers of Board members by province.

The 342 centres that answered this question have a total of 4,550 members on their Boards of Directors. The overall average is 13.3 Board members, the standard deviation is 5.8 and the interprovincial variance in this average is significant at p = .000.

Table 7.7

Total and Average Number of Board Members by Province

Province	Number of members	Average	Number of centres
Newfoundland	168	14	12
Nova Scotia	484	16	30
Prince Edward Island	141	14	10
New Brunswick	540	13.5	40
Quebec	657	10.9	60
Ontario	662	14.7	45
Manitoba	586	16.7	35
Saskatchewan	519	12	43
Alberta	415	12.9	32
British Columbia	378	10.8	35
Total	**4,550**	**13.3**	**342**

Interprovincial variance significant at .000

Analysis of the average number of Board members in public and private centres reveals a variance significant at .009: public organizations have an average of 11.4 members on their Boards compared with 13.6 for private non-profit organizations (see Table 7.8).

Table 7.8

Total and Average Number of Board Members versus Centre's Status

Status	Number of members	Average	Number of centres
Public	603	11.4	53
Private non-profit	3,925	13.6	288
Total	**4,528**	**13.3**	**341**

Variance in number of members by centre's status: significant at .009.

Elected Members

The average number of elected Board members is 8.4; the others are appointees or ex officio members. The term "elected member" refers strictly to the election process and not to the member's status. Thus, elected members do not all come from the local community or from among the centre's users; they may come from among the centre's professional or administrative staff, as is the case for example in Quebec's CLSCs. As for non-elected members, they may also be chosen from the population or represent government bodies, private associations or interest groups in the community.

Table 7.9 presents the total number of elected members by province, regardless of their status. We see that elected members represent, on average, over 50% of the centres' Boards (8.4 members out of a total 13.3 members). Interprovincial differences are not significant in this respect.

Table 7.9

Total Number of Elected Members by Province

Province	Number of elected members	Average	Number of respondents
Newfoundland	142	8.9	16
Nova Scotia	274	8.1	34
Prince Edward Island	63	6.3	10
New Brunswick	284	6.6	43
Quebec	462	7.7	60
Ontario	374	7.6	49
Manitoba	442	10.8	41
Saskatchewan	410	9.3	44
Alberta	356	10.8	33
British Columbia	270	7.3	37
Total	**3,077**	**8.4**	**367**

Interprovincial variance not significant.

As was the case with the total number of Board members, the average number of elected members varies significantly (p = .009) between public and private centres, the private centres having more elected members (see Table 7.10).

In addition to whether Board members are elected or appointed, it is important to know their status. We therefore made a distinction between citizen representatives (users, representatives of volunteer associations, representatives of the general public, volunteers) and "other representatives" (staff, government, organizations).

Table 7.10

Total Number of Elected Board Members by Centre's Status

STATUS	NUMBER OF MEMBERS	AVERAGE	NUMBER OF RESPONDENTS
Public	352	5.9	59
Private non-profit	2,708	8.8	307
Total	**3,050**	**8.3**	**(366)**

Variance in number of members by centre's status: significant at .009.

Table 7.11 shows the average number of "other representatives" per centre in each province.

We find that of the average 13.3 Board members per centre, only 2.8 fall into the category of "other representatives."

As the Boards of Directors have a large majority of local community representatives, they provide a certain guarantee that the needs and interests of the community will be taken into account by the administration. The power of local communities, in theory at least, does not appear to be threatened in any province by the composition of the Boards of Directors and the balance of forces on the Boards.

The average number of "other representatives" (staff, government, organizations) on the Board varies significantly according to the centre's status (p = .000); public centres have more members of this type on average (see Table 7.12).

Table 7.11

Other Board Members by Province			
Province	Number	Average	Number of respondents
Newfoundland	40	2.5	16
Nova Scotia	128	3.8	34
Prince Edward Island	18	1.8	10
New Brunswick	97	2.3	43
Quebec	210	3.5	60
Ontario	139	2.8	49
Manitoba	155	3.8	41
Saskatchewan	81	1.8	44
Alberta	72	2.2	33
British Columbia	72	1.9	37
Total	**1,012**	**2.8**	**367**

Interprovincial variance not significant.

Table 7.12

Other Board Members versus Centre's Status			
Status	Number of members	Average	Number of respondents
Public	267	4.5	59
Private non-profit	741	2.4	307
Total	**1,008**	**2.8**	**366**

Variance between centres by status: significant at .000.

OPERATION OF BOARD OF DIRECTORS

Meetings

The Boards hold an average of 10.8 meetings per year. The median figure is 11 meetings per year. In Table 7.13, we observe that 46% of the Boards meet 10, 11 or 12 times per year. We may assume that most of the Boards meet about once a month, with somewhat more time between meetings during the summer.

Table 7.13

Number of Board Meetings per Year

Number of meetings per year	Number of centres	%
1 to 9	170	49
10 to 12	162	46
13 or more	17	5
Total	**349**	**100**

Ethnic Groups

Ethnic representation on the Boards of Directors is significantly higher in centres serving heterogeneous populations than in those serving homogeneous populations (p = .004). Sixty-two per cent of centres targeting populations that include minority ethnic groups have representatives of these groups on their Boards. While this is a high figure, it still remains that 38% of the centres serving heterogeneous populations have not yet opened their Boards to members of ethnic groups (see Table 7.14).

Table 7.14

Ethnic Representation on Board of Directors versus Ethnic Composition of Population

Population	Ethnic Representation (%)		Number
	Yes	No	
Homogeneous	42	58	(89)
Heterogeneous	62	38	(136)
p = .004, Cramer's V = .20		**Total**	**(225)**

Terms of Office

The centres' statutes appear to provide for adequate mechanisms for renewing the Boards. Ninety-six per cent of centres reported that Board members serve fixed terms of office of between one and three years; the terms are an average of 2.2 years in length (see Table 7.15).

Table 7.15

Board Members' Terms of Office

TERMS OF OFFICE	*N*	%
2 years or less	158	62
3 years	87	34
4 years or more	9	4
Total	**254**	**100**

Average term of office: 2.2 years

To sum up, even a summary analysis of forms of public participation and of the composition and operating methods of the Boards of Directors reveals a rather narrow range of forms of participation, both in the identification of needs and in decision making. The most common participatory mechanism is election to the Board of Directors; elected public representatives constitute a large majority on the Boards. The composition of the Boards and the operating practices adopted by the centres appear to make the Boards adequate instruments through which the local communities served by the centres can express their interests and needs. Some aspects could, however, be further developed, particularly the representation of minority ethnic groups on the Boards.

Chapter 8

FINANCIAL SITUATION

We asked a number of questions related to the financial situation of the respondents. In this chapter, we have assembled all the data obtained concerning budgets, sources of funding, and methods of funding.

Budgets (1987-1988)

One of the most common observations concerning the budgets of community centres in all provinces is that the centres are chronically under-funded.

In order to obtain the most objective possible information on the budgetary situation of the centres studied, we asked the following question concerning their budgets for the last fiscal year for which figures were available:

"What is the total budget of the Centre for the 1987-1988 fiscal year (including, possibly, protected budget allotments)?"

Among the 340 centres that provided the information requested, the average annual budget was under $1 million ($820,000). Interprovincial variance in averages is significant at .009, allowing us to state that the level of funding varies considerably from one province to another and that interprovincial differences are statistically significant (see Table 8.1). It must be noted, however, that the budget figures for Ontario and Quebec date from 1986-87.

Table 8.1

Centre Budgets by Province

Province	Total budget ($)	Average per centre ($)
Newfoundland	6,483,384	463,099
Nova Scotia	18,473,580	577,299
Prince Edward Island	2,225,300	222,530
New Brunswick	13,706,411	351,446
Quebec	50,570,221	936,486
Ontario	66,763,436	1,451,379
Manitoba	41,619,067	1,067,156
Saskatchewan	19,383,101	484,578
Alberta	31,669,162	989,661
British Columbia	27,688,013	814,353
TOTAL	**278,581,675**	**819,358**

Interprovincial variance in provincial averages significant at .009.

We also find significant variance (p = .001) between the average budgets of public and private non-profit community centres (see Table 8.2).

Table 8.2

Centre Budgets by Province and Status

	Public		Private	
Province	Total ($)	Average ($)	Total ($)	Average ($)
Newfoundland	300,000	150,000	6,183,384	515,282
Nova Scotia	7,520,000	1,253,333	10,853,580	421,292
Prince Edward Island	----	----	2,225,300	222,530
New Brunswick	1,768,000	294,667	11,938,411	361,770
Quebec	42,855,910	2,380,884	7,714,311	214,286
Ontario	12,255,779	2,042,630	54,507,657	1,362,691
Manitoba	1,934,382	967,191	37,980,185	1,085,148
Saskatchewan	3,005,459	300,546	16,377,642	545,921
Alberta	4,640,000	1,546,667	27,029,162	932,040
British Columbia	----	----	27,688,013	814,353
Total	**74,279,530**	**1,401,500**	**202,637,645**	**708,523**

Variance by status: p = .001

The average budget of all the public centres studied is twice as high as that of the private non-profit centres. In some provinces, however—notably Newfoundland, New Brunswick, Manitoba and Saskatchewan—the private centres have larger budgets than do the public centres. The widest gap between the average budgets of private and public centres was found in Quebec, due to the CLSC system: public community centres in Quebec have average budgets 11 times higher than private non-profit centres.

The gap between the budgets of centres serving the entire population of a territory and those serving specific populations is also significant. We find (see Table 8.3) that centres serving the entire population have considerably larger budgets than those serving specific populations ($1.2 million versus $452,500).

Table 8.3

Centre Budgets by Province and Target Population

	Entire pop.		Specific pop.	
Province	Total ($)	Average ($)	Total ($)	Average ($)
Newfoundland	4,824,774	1,608,258	1,658,610	150,783
Nova Scotia	9,590,712	871,883	8,882,868	422,994
Prince Edward Island	350,000	350,000	1,875,300	208,367
New Brunswick	6,639,078	301,776	7,067,333	415,725
Quebec	45,388,633	2,063,119	5,181,588	161,925
Ontario	53,256,351	1,902,012	13,507,085	750,394
Manitoba	23,219,867	1,289,993	18,399,200	876,152
Saskatchewan	17,432,815	697,313	1,790,286	127,876
Alberta	21,082,699	1,621,746	10,586,463	557,182
British Columbia	15,184,737	949,046	12,503,276	694,626
Total	**196,969,666**	**1,238,802**	**81,452,009**	**452,511**

Variance by target population: p = .000

This observation holds for every province except New Brunswick. We find the greatest gap in Quebec, where centres providing services to the entire population have budgets 12 times greater than centres serving specific populations, which again reflects the existence of the CLSC system in Quebec.

There is significant variance in average budgets according to the nature of the services offered (p = .000). Centres offering health services only or integrated services receive much higher funding than those offering social services only (see Table 8.4).

Table 8.4

Centre Budgets by Province and Nature of Services

	HEALTH SERVICES		SOCIAL SERVICES		INTEGRATED SERVICES	
PROVINCE	TOTAL ($)	AVERAGE ($)	TOTAL ($)	AVERAGE ($)	TOTAL ($)	AVERAGE ($)
Nfld.	230,000	230,000	913,800	152,300	5,339,584	762,797
N.S.	1,641,000	820,500	8,450,868	422,543	8,381,712	838,171
P.E.I.	----	----	1,044,300	149,186	1,181,000	393,667
N.B.	3,264,818	652,964	6,550,289	284,795	3,541,304	354,130
Que.	359,765	179,882	3,167,344	143,970	47,043,112	1,568,103
Ont.	20,075,209	2,509,401	16,902,365	734,885	29,785,862	1,985,724
Man.	----	----	22,205,700	965,465	19,413,367	1,213,335
Sask.	1,199,500	171,357	1,681,444	140,120	16,502,157	785,817
Alta.	7,519,383	1,253,230	7,162,780	421,340	16,986,999	1,887,444
B.C.	----	----	11,283,013	451,320	16,405,000	1,822,778
Total	**34,289, 675**	**1,106,119**	**79,361,903**	**445,853**	**164,580,097**	**1,266,001**

Interprovincial variance by nature of services: p = .000

Recurrence

The recurrence of budgets is an indicator of continuity. Centres whose budgets are not guaranteed from one year to the next are not certain of survival, for their budgets depend on a discretionary choice by the funding bodies. Non-recurrent budgets also create a number of difficulties for the organizations involved, for each year they must devote valuable energies to securing funding, often at the expense of services to the community.

Of the 286 centres that responded to this question, 13.6% reported they have annual budgets with no guaranteed recurrence. On the other hand, 32% of respondents have budgets that are recurrent in their entirety.

For the purposes of this report, we have divided the centres into two categories according to whether the recurrent portion of their budget is greater than or less than 50%.

There is significant interprovincial variance (p = .001) as can be seen from Table 8.5. Two provinces in particular account for this variance: we note that 76% of all the centres studied can count on the renewal of over half their budgets, but in Ontario and Nova Scotia the figure rises to over 95%. On the other hand, the majority of centres in Quebec (51%) have budgets of which 50% or less is recurrent.

Table 8.5

Recurrence of Budgets by Province

	Recurrent Portion		
PROVINCE	50% OR LESS %	51% OR MORE %	TOTAL
Newfoundland	22	78	(9)
Nova Scotia	5	95	(20)
Prince Edward Island	25	75	(8)
New Brunswick	25	75	(32)
Quebec	51	49	(57)
Ontario	2	98	(46)
Manitoba	23	77	(31)
Saskatchewan	23	77	(30)
Alberta	29	71	(28)
British Columbia	13	87	(31)
Total	**24**	**76**	**(292)**

p = .000, Cramer's V = .38

We also find, in Table 8.6, that the recurrent portion of centre budgets varies significantly according to the centre's status, target population, and nature of services offered. Public centres, those serving the entire population of a territory, and those offering health services tend to have a larger recurrent portion (see Table 8.6).

We may suppose that budget recurrence is also related to a centre's years of existence. Our data did not, however, allow us to establish a direct correlation between a centre's years of existence and the percentage of its budget that is recurrent.

By performing averaging tests and by dividing centres according to whether the recurrent portion of their budget is above or below 25%, or above or below 75%, however, we were able to identify a significant difference in the average age of the centres in question.

Table 8.6

Recurrence of Budgets versus Centre's Status

	RECURRENT PORTION		
	50% OR LESS	51% OR MORE	TOTAL
STATUS	%	%	
Public	2	98	(46)
Private non-profit	28	72	(245)
Total			**(291)**

p = .000, Phi = .22

Recurrence of Budgets versus Target Population

	RECURRENT PORTION		
	50% OR LESS	51% OR MORE	TOTAL
TARGET POPULATION	%	%	
Total pop.	15	85	(134)
Specific pop.	31	69	(159)
Total			**(293)**

p = .002, Phi = .19

Recurrence of Budgets versus Nature of Services

	RECURRENT PORTION		
	50% OR LESS	51% OR MORE	TOTAL
NATURE OF SERVICES	%	%	
Health	11	89	(28)
Social	29	71	(156)
Integrated	19	81	(109)
Total			**(293)**

p = .04, Cramer's V = .14

The centres with budgets of which 25% or less is recurrent (49) have been in existence an average of 10.9 years, while those with budgets of which 75% or more is recurrent (195) have been in existence an average of 18.7 years.

Another averaging test was performed on centres with 10 years of existence or less (138) and those with 21 years of existence or more (50). A significant difference was found in the recurrent portions of their budgets (p = .000). Sixty-five per cent of the centres that have been in existence for 1 to 10 years have budgets of which at least 75% is recurrent, compared with 86% of the centres in existence for over 21 years.

Sources of Funding

Community organizations rely on various sources of funding, including:

- public funds (departments or agencies of the three levels of government);
- private funds (foundations, United Way, religious institutions, business, etc.);
- self-financing (operating revenues, dues, fundraising campaigns, etc.).

The majority of the centres studied (70.8%) receive mixed funding—that is, funds from both public and private sources. Few centres (4.1%) rely entirely on private funding. We find significant variance, however, between the sources of funding of public and private centres (p = .000) (see Table 8.7).

Table 8.7

Sources of Funding versus Centre's Status

	Public		Private non-profit		Total	
Source of funding	*N*	%	*N*	%	*N*	%
Public	(35)	40.7	(51)	59.3	(86)	25.1
Private	(1)	7.2	(13)	92.9	(14)	4.1
Public and private	(21)	8.7	(221)	91.3	(242)	70.8
Total	**(57)**	**16.7**	**(285)**	**83.3**	**(342)**	**100**

Table 8.8

Number of Sources of Funding versus Centre's Status

	Public		Private non-profit		Total	
Sources of funding	*N*	%	*N*	%	*N*	%
One	(36)	40.0	(54)	60.0	(90)	26.3
Two	(12)	12.1	(87)	87.9	(99)	28.9
Three	(9)	5.9	(144)	94.1	(153)	44.7
Total	**(57)**	**16.7**	**(285)**	**83.3**	**(342)**	**100**

Of the centres with mixed funding, 8.7% are public and 91.3% are private non-profit organizations. The proportions are similar for centres that receive private funding, but a considerable difference can be seen in the case of public funding, which more often goes to public organizations.

If we analyze the data according to whether a centre has one, two or three sources of funding, we find significant variance (p = .000) between private and public centres (see Table 8.8). Overall, a significant proportion of the centres have three sources of funding (44.7%); 94% of these are private non-profit organizations.

It should be recalled that public funding can be provided by the federal, provincial or municipal government.

If we examine public sources of funding, it appears that provincial governments make the greatest contribution to the centres' budgets while municipalities contribute the smallest proportion (see Table 8.9).

Table 8.9

Proportion of Centre Budgets Provided by Each Level of Government

Percent of budget	Federal %	Provincial %	Municipal %
10% or less	26.4	6.3	62.4
11 to 50%	49.5	34.5	31.2
51 to 100%	24.1	59.2	6.5
Total	**100**	**100**	**100**

If we combine the contributions of the three levels of government, we find that a large percentage of the centres (78%) obtain over 50% of their budgets from these sources.

Funding is also obtained from private bodies and through self-financing. While these sources of funding are not negligible, they account for a smaller proportion of the centres' budgets than do public bodies.

Table 8.10

Proportion of Centre Budgets Obtained from Public Sources

PERCENT OF BUDGET	PUBLIC SOURCES (%)
10% or less	3.1
11 to 50%	18.9
51 to 100%	78.1
Total	100

Cross-tabulation of sources of funding (public or private) with the centre's status and the nature of the services offered did not reveal any statistically significant relationships. When, however, we break down the proportions of centre budgets derived from public and private sources, we find a significant difference in the proportion obtained from private sources by public and private non-profit centres. Of the centres that obtain over 50% of their funding from private sources, 100% are private non-profit organizations. Eighty-six per cent of the public centres receive 10% of their budgets from private sources, compared with only 40% of private non-profit organizations (see Table 8.12).

Table 8.11

Proportion of Centre Budgets Obtained from Private Sources (Private Bodies and Self-Financing)

	SOURCE OF FUNDING	
PERCENT OF BUDGET	PRIVATE BODIES %	SELF-FINANCING %
10% or less	42.3	53.5
11 to 50%	49.1	36.4
51 to 100%	8.6	10.1
Total	100	100

Table 8.12

Proportion of Centre Budgets Obtained from Private Sources versus Centre's Status

	Status			
	Public		Private	
% Private funding	*N*	%	*N*	%
10% or less	(6)	86	(68)	40
11 to 50%	(1)	14	(85)	51
51 to 100%	(0)	0	(15)	9
Total	**(7)**	**100**	**(168)**	**100**

We also find a significant difference in the level of private funding according to the nature of services. Most health services and integrated services centres receive a relatively small percentage of their budgets from private sources, whereas the majority of centres offering social services receive a significant proportion of their budgets (10% to 50%) from private sources (Table 8.13).

Table 8.13

Proportion of Budget Obtained from Private Sources versus Nature of Services

	Nature of services					
	Health		Social		Integrated	
% Private Funding	*N*	%	*N*	%	*N*	%
10% or less	(9)	64	(36)	33	(29)	55
11 to 50%	(5)	36	(60)	56	(21)	39
51 to 100%	(0)	0	(12)	11	(3)	6
Total	**(14)**	**100**	**(108)**	**100**	**(53)**	**100**

Funding Formulae

Community centres can be funded according to various formulae: global funding, funding on a case-by-case basis, by volume of clients, by program, per capita or by other methods.

Table 8.14 shows the diversity of funding methods among the centres studied.

Table 8.14

Distribution of Centres According to Method of Funding

METHOD OF FUNDING	CENTRES N	 %
Global	(89)	28
Case-by-case (volume of clients)	(29)	9
Specific programs	(73)	23
Per capita	(9)	3
Other methods/combinations	(128)	37
Total	**(328)**	**100**

Global funding and funding by specific program appear to be the most common methods. Over one third of the centres receive funding of more than one type.

To sum up, we have made the following observations in this chapter: community health and social service centres have relatively modest budgets; and the size of their budgets varies primarily according to whether they are public or private organizations and the nature of the services offered. We also find that provincial government funding is more substantial than funding from the various other sources.

Chapter 9

INTERPROVINCIAL COMPARISONS

The significance of interprovincial variations has been noted frequently throughout the preceding chapters. In this chapter, we will present the overall data for each province. The tables follow the general structure of this report to make them easier to read. In addition, the tables for all provinces are constructed in the same way to allow comparison of the data for a given province with the data for all the other provinces. For each variable, we have identified statistically significant variations and the direction of each variation. The statistical tests used allowed us to compare each province with the other provinces taken as a whole. Where we indicate that the difference is not significant, it may be deduced that the data for the province in question does not vary from the data for all the respondents in the other provinces.

Each table lists fifty items of information. For each item, the figure for the province in question is compared with the overall figure for all the respondents in the other provinces. The evidence is organized under seven headings: general characteristics, services, human resources, accessibility, participation, Board of Directors, budget. As there are 10 provinces, a total of 500 comparisons were made; for 360 of them, or 72%, the differences were not significant. This is a first indication of the degree of homogeneity of the community health and social service centres that participated in this study. The 368 centres studied share a number of characteristics and their degree of similarity indicates that we are dealing with a new type of organization identified with the community approach and present in all provinces.

In this chapter, we will note only significant differences between the respondents in each province in turn and those in the rest of Canada.

NEWFOUNDLAND

The 16 centres in Newfoundland resemble those in the other provinces in many respects, particularly in terms of general characteristics, types of services offered, accessibility, composition of the Board of Directors, average budget and recurrent portion of budget.

They differ, however, in the following respects:

- they are more likely to target specific populations;
- both public and private centres with smaller numbers of employees and volunteers tend to offer only social services or integrated services, mainly to specific populations;
- we generally find a lower level of public participation; and
- the centres offering social services and those serving specific populations have smaller budgets than is observed elsewhere.

In 1986-1987, Newfoundland's Department of Social Services funded 91 private non-profit organizations offering social services (to the tune of $11.1 million). The province does not have a well-defined policy concerning support for community health and social service organizations and evaluation of the centres is neither systematic nor formal. Community services are better developed in the capital but are scarce outside the capital and in rural areas.

Table 9.1

Interprovincial Comparisons
Newfoundland(1)

Characteristics	%	Deviation from all other provinces	Comments
Years of existence(2)			
1 to 10 years	56	N.S.	
11 to 20 years	31		
21 years and more	13		
Founding body(2)			
Public	12	N.S.	
Private	75		
Public and private	13		
Centre's status(2)			
Public	19	N.S.	
Private non-profit	81		
Target population(2)			
Total population	19	.004	Newfoundland centres more often serve specific populations
Specific population	81		
Territory served(2)			
Urban	57	N.S.	
Rural	21		
Other	22		
Population's ethnic composition(3)			
Homogeneous	71	N.S.	
Heterogeneous	29		
Nature of services offered (2)			
Health only	6	N.S.	
Social only	38		
Health and social	56		

Table 9.1 (cont'd)

Types of services(2)	%	Deviation from all other provinces	Comments
Information and referral	87		No significant difference in services offered in Newfoundland and the other centres studied
Health education	73		
Organizing and participating in public opinion campaigns	67		
Participation in coalitions	80		
Primary prevention	53		
Setting up community groups	67		
Establishing self-help groups	67		
Outreach	73		
Minor health emergencies	27		
Psycho-social services	67		
Medical consultations	20		
Psycho-social consultations	47		
Social reintegration services	53		
Specialized medical services	---		
Home care	27		
Loaning space	40		
Loaning staff	27		

Table 9.1 (cont'd)

Human resources[2]	**Average number per centre**	**Deviation from all other provinces**	**Comments**
Health centres	4.0	N.S.	N = 1
Social centres	3.8	.000	Lower
Integrated services centres	12.2	.002	Lower
All centres in the province	**8.6**	**.000**	**Lower**
Public organizations	2.3	.000	Lower
Private organizations	10.0	.019	Lower
Centres offering services to the entire population	29.3	N.S.	N = 3
Centres offering services to a specific population	3.8	.000	Lower
Paid staff (positions)	8.6	.000	Lower
Volunteers, unpaid staff (persons)	15.1	.010	Lower

Table 9.1 (cont'd)

Accessibility[2]	**Rating**	**Deviation from all other provinces**	**Comments**
Province's rating on index	12.5	N.S.	
Average rating of all other respondents on index	12.6		

Participation[2]	**Rating**	**Deviation from all other provinces**	**Comments**
Province's rating on index	3.5	.010	N = 4
Average rating of all other respondents on index	10.8		

Composition of Board of Directors[2]	**Average number**	**Deviation from all other provinces**	**Comments**
Elected members	8.9	N.S.	
Appointees	2.5	N.S.	
Citizens	9.7	N.S.	
Other members	2.5	N.S.	
Total members*	12.1	N.S.	

*** Total does not always correspond to the sum of the variables considered due to information missing from questionnaires.**

Table 9.1 (cont'd)

Budget (average)(2)	**$**	**Deviation from all other provinces**	**Comments**
Public centres	150,000	N.S.	N = 2
Private centres	515,282	N.S.	
Centres offering services to the entire population of a territory	1,608,258	N.S.	
Centres offering services to a specific population	150,783	.000	Lower
Centres offering health services	230,000	N.S.	N = 1
Centres offering social services	152,300	.001	Lower
Centres offering integrated services	762,798	N.S.	
All centres in the province	**463,099**	**N.S.**	

Table 9.1 (cont'd)

Average proportion of recurrent budget(2)	%	Deviation from all other provinces	Comments
Province	66.3	N.S.	
All other provinces	72.8		

(1) N = 16

(2) T-test used to analyze difference between provincial and national averages (continuous random variables)

(3) Chi-square test used to analyze differences (nominal variables)

PRINCE EDWARD ISLAND

The 10 Prince Edward Island centres (all private non-profit organizations) resemble centres in the other provinces in the following respects: years of existence, territory served, nature of services offered, types of services offered, the human resources of centres offering services to the entire population, composition of the Board of Directors, the budgets of centres offering services to the entire population of a territory and of those providing integrated services, and the recurrent portion of the budget.

They differ from the other centres, however, in the following respects:

- the centres were more frequently created through the joint initiative of public and private bodies;
- they are more likely to offer services to specific populations;
- they deal with more ethnically homogeneous populations;
- the average number of paid positions is below the national average except in centres serving the entire population;
- the average budget is lower in the case of centres offering social services and those targeting specific populations; and
- the average budget of the centres in the province is below the national average.

Table 9.2

Interprovincial Comparisons
Prince Edward Island(1)

Characteristics	%	Deviation from all other provinces	Comments
Years of existence(2)			
1 to 10 years	40	N.S.	
11 to 20 years	40		
21 years and more	20		
Founding body(3)			
Public	---	.02	Fewer private bodies; more "public and private"
Private	40		
Public and private	60		
Centre's status(3)			
Public	---	N.S.	
Private non-profit	100		
Target population(3)			
Total	10	.04	More likely to serve specific population
Specific	90		
Territory served(3)			
Urban	70	N.S.	
Rural	---		
Other	30		
Population's ethnic composition(3)			
Homogeneous	89	.04	More homogeneous
Heterogeneous	11		
Nature of services offered(3)			
Health only	---	N.S.	
Social only	70		
Health and social	30		

Table 9.2 (cont'd)

Types of services (2)	%	Deviation from all other provinces	Comments
Information and referral	75		No significant difference in services offered in P.E.I. and the other centres studied
Health education	75		
Organizing and participating in public opinion campaigns	78		
Participation in coalitions	89		
Primary prevention	38		
Setting up community groups	38		
Establishing self-help groups	63		
Outreach	89		
Minor health	---		
Psycho-social services	50		
Medical consultations	38		
Psycho-social consultations	57		
Social reintegration services	71		
Specialized medical services	14		
Home care	25		
Loaning space	67		
Loaning staff	---		

Table 9.2 (cont'd)

Human resources(2)	Average number per centre	Deviation from all other provinces	Comments
Health centres	---	---	
Social centres	4.9	.000	Lower
Integrated services centres	9.7	.003	Lower
All centres in the province	**6.3**	**.000**	**Lower**
Public organizations	---	---	
Private organizations	6.3	.000	Lower
Centres offering services to the entire population	6.0	N.S.	N = 1
Centres offering services to a specific population	6.3	.006	Lower
Paid staff (positions)	6.3	.000	Lower
Volunteers, unpaid staff (persons)	15.5	N.S.	

Table 9.2 (cont'd)

Accessibility(2)	**Rating**	**Deviation from all other provinces**	**Comments**
Province's rating on index	12.4	N.S.	
Average rating of all other respondents on index	12.6		

Participation(2)	**Rating**	**Deviation from all other provinces**	**Comments**
Province's rating on index	3.0	N.S.	N = 2
Average rating of all other respondents on index	10.8		

Composition of Board of Directors(2)	**Average number**	**Deviation from all other provinces**	**Comments**
Elected members	6.3	N.S.	
Appointees	6.1	N.S.	
Citizens	8.6	N.S.	
Other members	1.8	N.S.	
Total members*	10.4	N.S.	

*** Total does not always correspond to the sum of the variables considered due to information missing from questionnaires.**

Table 9.2 (cont'd)

Budgets (average)[2]	$	Deviation from all other provinces	Comments
Public centres	----------	-------	N = 0
Private centres	222,530	.000	Lower
Centres offering services to the entire population of a territory	350,000	N.S.	N = 1
Centres offering services to a specific population	208,366	.047	Lower
Centres offering health services	----------	-------	N = 0
Centres offering social services	149,185	.000	Lower
Centres offering integrated services	393,666	N.S.	
All centres in the province	**222,530**	**.000**	**Lower**

Table 9.2 (cont'd)

Average recurrent proportion of budget[2]	%	Deviation from all other provinces	Comments
Province	83	N.S.	
All other provinces	72		

(1) N = 10

(2) T-test used to analyze difference between provincial and national averages (continuous random variables)

(3) Chi-square test used to analyze differences (nominal variables)

NOVA SCOTIA

The 34 centres in Nova Scotia share a number of features with the centres in the rest of the country: general characteristics, types of services offered, human resources, accessibility, composition of the Board of Directors (except for appointees), the average budget of public centres and the recurrent portions of the budgets of all centres.

They differ from the other centres, however, in the following respects:

- the centres were more often founded by private bodies;
- the average number of salaried positions is lower;
- the average number of positions in private community organizations is lower;
- public participation in the identification of needs and decision making is weaker;
- the average number of appointees on the Boards of Directors is higher; and
- the average budget of private centres is higher than the national average for centres of this type.

Table 9.3

Interprovincial Comparisons
Nova Scotia (1)

Characteristics	%	Deviation from all other provinces	Comments
Years of existence(2)			
1 to 10 years	50	N.S.	
11 to 20 years	27		
21 years and more	23		
Founding body (3)			
Public	---	.04	More private bodies; more "public and private"
Private	68		
Public and private	32		
Centre's status(3)			
Public	18	N.S.	
Private non-profit	82		
Target population(3)			
Total population	35	N.S.	
Specific population	65		
Territory served (3)			
Urban	50	N.S.	
Rural	22		
Other	28		
Population's ethnic composition(3)			
Homogeneous	56	N.S.	
Heterogeneous	44		
Nature of services offered(3)			
Health only	6	N.S.	
Social only	62		
Health and social	32		

Table 9.3 (cont'd)

Types of services (2)	%	Deviation from all other provinces	Comments
Information and referral	90		No significant difference in services offered in Nova Scotia and the other centres studied
Health education	71		
Organizing and participating in public opinion campaigns	52		
Participation in coalitions	69		
Primary prevention	66		
Setting up community groups	67		
Establishing self-help groups	50		
Outreach	68		
Minor health emergencies	23		
Psycho-social services	67		
Medical consultations	27		
Psycho-social consultations	63		
Social reintegration services	57		
Specialized medical services	10		
Home care	32		
Loaning space	58		
Loaning staff	28		

Table 9.3 (cont'd)

Human resources(1)	Average number per centre	Deviation from all other provinces	Comments
Health centres	17.0	N.S.	
Social centres	12.2	N.S.	
Integrated services centres	21.0	N.S.	
All centres in the province	**15.3**	**.02**	**Lower**
Public organizations	33.0	N.S.	
Private organizations	11.5	.001	Lower
Centres offering services to the entire population	21.6	N.S.	
Centres offering services to a specific population	11.9	N.S.	
Paid staff (positions)	15.3	.02	Lower
Volunteers, unpaid staff (persons)	31.1	N.S.	

Table 9.3 (cont'd)

Accessibility(2)	**Rating**	**Deviation from all other provinces**	**Comments**
Province's rating on index	12.9	N.S.	
Average rating of all other respondents on index	12.5		

Participation(2)	**Rating**	**Deviation from all other provinces**	**Comments**
Province's rating on index	5.4	.004	Lower than average
Average rating of all other respondents on index	10.9		

Composition of Board of Directors(2)	**Average number**	**Deviation from all other provinces**	**Comments**
Elected members	8.1	N.S.	Higher
Appointees	5.7	.04	Higher
Citizens	12.4	N.S.	
Other members	3.8	N.S.	
Total members*	15.1	N.S.	

*** Total does not always correspond to the sum of the variables considered due to information missing from questionnaires.**

Table 9.3 (cont'd)

Budget (average)[2]	$	Deviation from all other provinces	Comments
Public centres	1,253,333	N.S.	
Private centres	421,291	.016	Higher
Centres offering services to the entire population of a territory	871,882	N.S.	
Centres offering services to a specific population	422,993	N.S.	
Centres offering health services	820,500	N.S.	N = 2
Centres offering social services	422,543	N.S.	
Centres offering integrated services	838,171	N.S.	
All centres in the province	**577,299**	**N.S.**	

Table 9.3 (cont'd)

Average recurrent proportion of budget[2]	%	Deviation from all other provinces	Comments
Province	82.1	N.S.	
All other provinces	71.9		

(1) N = 34

(2) T-test used to analyze difference between provincial and national averages (continuous random variables)

(3) Chi-square test used to analyze differences (nominal variables)

NEW BRUNSWICK

The 43 centres in New Brunswick resemble those in the other provinces in terms of the following features: general characteristics, most of the types of services offered, human resources in private centres offering health care or social services to specific populations, accessibility, public participation, composition of the Board of Directors, the average budget of centres offering health care or social services to specific populations, and the recurrent portion of budget in all centres. They differ from the other centres, however, in the following respects:

- the following services are found less frequently: information and referral, organizing or participating in public opinion campaigns, participation in coalitions, setting up community groups, psycho-social services in crisis situations, psycho-social consultations;
- public centres offering integrated services to the entire population of a territory have a smaller average number of positions (paid positions and number of volunteers);
- New Brunswick's centres have an average budget smaller than the national average; and
- average budgets are smaller for centres offering services to the entire population and those providing integrated services.

The percentage of multi-service centres offering integrated services is among the lowest in Canada, along with the centres studied in British Columbia.

Table 9.4

Interprovincial Comparisons
New Brunswick(1)

Characteristics	%	Deviation from all other provinces	Comments
Years of existence(2)			
1 to 10 years	74	N.S.	
11 to 20 years	15		
21 years and more	11		
Founding body (3)			
Public	12	N.S.	
Private	63		
Public and private	25		
Centre's status (3)			
Public	16	N.S.	
Private non-profit	84		
Target population (3)			
Total population	56	N.S.	
Specific population	44		
Territory served (3)			
Urban	42	N.S.	
Rural	26		
Other	32		
Population's ethnic composition(3)			
Homogeneous	64	N.S.	
Heterogeneous	36		
Nature of services offered(3)			
Health only	14	N.S.	
Social only	60		
Health and social	26		

Table 9.4 (cont'd)

Types of services(2)	%	Deviation from all other provinces	Comments
Information and referral	80	.006	Less frequent
Health education	66	N.S.	
Organizing and participating in public opinion campaigns	37	.008	Less frequent
Participation in coalitions	37	.001	Less frequent
Primary prevention	66	N.S.	
Setting up community groups	42	.000	Less frequent
Establishing self-help groups	61	N.S.	
Outreach	53	N.S.	
Minor health emergencies	32	N.S.	
Psycho-social services	45	.000	Less frequent
Medical consultations	27	N.S.	
Psycho-social consultations	39	.000	Less frequent
Social reintegration services	54	N.S.	
Specialized medical services	8	N.S.	
Home care	38	N.S.	
Loaning space	48	N.S.	
Loaning staff	35	N.S.	

Table 9.4 (cont'd)

Human resources(7)	Average number per centre	Deviation from all other provinces	Comments
Health centres	23.5	N.S.	
Social centres	13.2	N.S.	
Integrated services centres	21.3	.03	Lower
All centres in the province	**16.4**	**.03**	**Lower**
Public organizations	14.7	.001	Lower
Private organizations	16.7	N.S.	
Centres offering services to the entire population	16.3	.001	Lower
Centres offering services to a specific population	16.5	N.S.	
Paid staff (positions)	16.4	.03	Lower
Volunteers, unpaid staff (persons)	21.7	.05	Lower

Table 9.4 (cont'd)

Accessibility[2]	Rating	Deviation from all other provinces	Comments
Province's rating on index	12.1	N.S.	
Average rating of all other respondents on index	12.6		

Participation[2]	Rating	Deviation from all other provinces	Comments
Province's rating on index	8.3	N.S.	
Average rating of all other respondents on index	10.8		

Composition of Board of Directors[3]	Average number	Deviation from all other provinces	Comments
Elected members	6.6	N.S.	
Appointees	4.9	N.S.	
Citizens	11.8	N.S.	
Other members	2.3	N.S.	
Total members*	14.0	N.S.	

* Total does not always correspond to the sum of the variables considered due to information missing from questionnaires.

Table 9.4 (cont'd)

Budgets (average) (2)	**$**	**Deviation from all other provinces**	**Comments**
Public centres	294,666	.000	Lower
Private centres	361,770	.005	Lower
Centres offering services to the entire population of a territory	301,776	.000	Lower
Centres offering services to a specific population	415,725	N.S.	
Centres offering health services	652,963	N.S.	
Centres offering social services	284,795	N.S.	
Centres offering integrated services	354,130	.000	Lower
All centres in the province	**351,446**	**.000**	**Lower**

Table 9.4 (cont'd)

Average recurrent proportion of budget[2]	%	Deviation from all other provinces	Comments
Province	66.3	N.S.	
All other provinces	72.8		

(1) N = 43

(2) T-test used to analyze difference between provincial and national averages (continuous random variables)

(3) Chi-square test used to analyze differences (nominal variables)

QUEBEC

The 60 centres in Quebec resemble centres in the other provinces in terms of the following features: target population and territory served, some of the types of services offered, human resources (paid employees and volunteers) except in public centres and those offering services to the entire population of a territory, accessibility, participation, and composition of the Board of Directors (except for appointees).

The 60 Quebec centres differ from the other centres studied in the following respects:

- the average age of the centres is lower;
- the centres are more likely to have been founded through the initiative of public bodies;
- there is a higher percentage of public centres;
- the centres serve more ethnically homogeneous populations;
- the following services are more frequently offered: primary prevention, setting up community groups and self-help groups, minor health emergencies, psycho-social services in crisis situations, psycho-social consultations, social reintegration services, home care, and loaning space to community groups;
- outreach work is done less frequently;
- the average number of positions is higher in public organizations offering services to the entire population; it is lower in private centres;
- the average number of appointees on the Boards of Directors is lower;
- average budgets are higher in public centres and those offering services to the entire population; they are lower in private centres, in centres offering services to specific populations and those offering social services; and
- the average recurrent portion of the budget is lower.

The most notable feature found in Quebec is the existence throughout the province of para-public community organizations known as Centres locaux de services communautaires (CLSCs). The relative weakness of the private non-profit community centre sector is due in part to the extent of public investment in the public community system.

Table 9.5

Interprovincial Comparisons
Quebec(1)

Characteristics	%	Deviation from all other provinces	Comments
Years of existence(2)		.01	Younger
1 to 10 years	52		
11 to 20 years	43		
21 years and more	5		
Founding body(2)		.01	More public bodies
Public	25		
Private	60		
Public and private	15		
Centre's status (2)		.002	More public status
Public	30		
Private non-profit	70		
Target population (2)		N.S.	
Total population	38		
Specific population	62		
Territory served (2)		N.S.	
Urban	58		
Rural	12		
Other	30		
Population's ethnic composition (2)		.000	More homogeneous
Homogeneous	85		
Heterogeneous	15		
Nature of services offered(2)		.04	More integrated services
Health only	5		
Social only	43		
Health and social	52		

Table 9.5 (cont'd)

Types of services[2]	%	Deviation from all other provinces	Comments
Information and referral	94	N.S.	
Health education	86	N.S.	
Organizing and participating in public opinion campaigns	70	N.S.	
Participation in coalitions	67	N.S.	
Primary prevention	85	.04	More frequent
Setting up community groups	89	.000	More frequent
Establishing self-help groups	84	.004	More frequent
Outreach	47	.01	Less frequent
Minor health emergencies	57	.004	More frequent
Psycho-social services	90	.001	More frequent
Medical consultations	47	N.S.	
Psycho-social consultations	87	.001	More frequent
Social reintegration services	79	.009	More frequent
Specialized medical services	10	N.S.	
Home care	70	.000	More frequent
Loaning space	71	.03	More frequent
Loaning staff	45	N.S.	

Table 9.5 (cont'd)

Human resources(2)	**Average number per centre**	**Deviation from all other provinces**	**Comments**
Health centres	35.7	N.S.	
Social centres	11.2	N.S.	
Integrated services centres	44.8	N.S.	
All centres in the province	29.9	N.S.	
Public organizations	68.7	.000	Higher
Private organizations	13.1	N.S.	
Centres offering services to the entire population	57.4	.004	Higher
Centres offering services to a specific population	12.6	N.S.	
Paid staff (positions)	29.8	N.S.	
Volunteers, unpaid staff (persons)	31.4	N.S.	

Table 9.5 (cont'd)

Accessibility[2]	Rating	Deviation from all other provinces	Comments
Province's rating on index	12.3	N.S.	
Average rating of all other respondents on index	12.6		

Participation[2]	Rating	Deviation from all other provinces	Comments
Province's rating on index	10.7	N.S.	
Average rating of all other respondents on index	10.7		

Composition of Board of Directors[2]	Average number	Deviation from all other provinces	Comments
Elected members	7.7	N.S.	
Appointees	2.5	.03	Lower
Citizens	7.4	N.S.	
Other members	3.5	N.S.	
Total members*	**10.9**	**N.S.**	

*** Total does not always correspond to the sum of the variables considered due to information missing from questionnaires.**

Table 9.5 (cont'd)

Budget (average) [2]	$	Deviation from all other provinces	Comments
Public centres	2,380,883	.000	Higher
Private centres	214,286	.000	Lower
Centres offering services to the entire population of a territory	2,063,119	.001	Higher
Centres offering services to a specific population	161,924	.000	Lower
Centres offering health services	179,882	N.S.	
Centres offering social services	143,970	.000	Lower
Centres offering integrated services	1,568,103	N.S.	
All centres in the province	936,485	N.S.	

Table 9.5 (cont'd)

Average recurrent proportion of budget (2)	%	Deviation from all other provinces	Comments
Province	50.5	.000	Less
All other provinces	78.0		

(1) N = 60

(2) T-test used to analyze difference between provincial and national averages (continuous random variables)

(3) Chi-square test used to analyze differences (nominal variables)

ONTARIO

The 49 centres in Ontario resemble the centres in the other provinces in terms of the following features: all general characteristics (except for years of existence and territory served), types of services offered, human resources, accessibility, participation, the composition of Board of Directors and average budget.

The 49 Ontario centres differ from the other centres studied in the following respects:

- the average age of the centres is higher;
- rural areas are less well represented;
- the following services are offered more frequently: organizing or participating in public opinion campaigns, primary prevention, specialized medical services, and home care;
- the average number of positions in social service centres is higher;
- the average number of appointees on the Boards of Directors is higher;
- the average budget of all centres is slightly higher, especially that of centres offering social services;
- the average recurrent portion of the budget is above the national average.

Ontario's community health and social services seem to benefit from the province's relative prosperity. However, the fact that health care and social services fall under the responsibility of two different government departments does not favour their integration at the community level. The two departments have different philosophies, approaches and experiences with respect to community services, even if both seek to promote a diversified system for a heterogeneous population and to maximize the efficiency and effectiveness of services. Municipalities have been involved traditionally in the delivery of community services, probably more so than elsewhere in Canada; they even provide a certain percentage of the funding for these services (20 to 25%). Community health centres remain a fringe phenomenon in Ontario: in 1982, the Mustard Commission estimated that only about

2.5% of the population is served by such centres. The existence of the Health Services Organizations (HSOs), which bring together doctors in private practice, seems to be the main obstacle to the development of community health centres in Ontario.

As for the Department of Community Social Services, it provides annual funding for about 1,800 private non-profit agencies and organizations. The act under which the department operates provides for various types of services, including community support services which do not focus on the individual but aim to improve social support for high-risk populations. This concept provides a basis for the development of community social services as defined in this study.

Table 9.6

Interprovincial Comparisons
Ontario(1)

Characteristics	%	Deviation from all other provinces	Comments
Years of existence (2)			
1 to 10 years	25		
11 to 20 years	47	.03	Older
21 years and more	28		
Founding body(2)			
Public	16		
Private	59	N.S.	
Public and private	25		
Centre's status (2)			
Public	12	N.S.	
Private non-profit	88		
Target population (2)			
Total population	59	N.S.	
Specific population	41		
Territory served (2)			
Urban	67		
Rural	2	.01	Less rural
Other	31		
Population's ethnic composition(2)			
Homogeneous	40	N.S.	
Heterogeneous	60		
Nature of services offered(2)			
Health only	16		
Social only	53	N.S.	
Health and social	31		

Table 9.6 (cont'd)

Types of services(2)	%	Deviation from all other provinces	Comments
Information and referral	95	N.S.	
Health education	87	N.S.	
Organizing and participating in public opinion campaigns	77	.04	More frequent
Participation in coalitions	74	N.S.	
Primary prevention	87	.02	More frequent
Setting up community groups	74	N.S.	
Establishing self-help groups	70	N.S.	
Outreach	52	N.S.	
Minor health emergencies	52	N.S.	
Psycho-social services	78	N.S.	
Medical consultations	54	N.S.	
Psycho-social consultations	75	N.S.	
Social reintegration services	52	N.S.	
Specialized medical services	27	.01	More frequent
Home care	68	.000	More frequent
Loaning space	55	N.S.	
Loaning staff	49	N.S.	

Table 9.6 (cont'd)

Human resources[2]	Average number per centre	Deviation from all other provinces	Comments
Health centres	25.1	N.S.	
Social centres	21.8	.04	Higher
Integrated services centres	64.0	N.S.	
All centres in the province	**35.2**	**N.S.**	
Public organizations	32.5	N.S.	
Private organizations	35.6	N.S.	
Centres offering services to the entire population	45.1	N.S.	
Centres offering services to a specific population	21.0	N.S.	
Paid staff (positions)	35.2	N.S.	
Volunteers, unpaid staff (persons)	26.8	N.S.	

Table 9.6 (cont'd)

Accessibility[2]	Rating	Deviation from all other provinces	Comments
Province's rating on index	13.1	N.S.	
Average rating of all other respondents on index	12.5		

Participation[2]	Rating	Deviation from all other provinces	Comments
Province's rating on index	10.9	N.S.	
Average rating of all other respondents on index	10.6		

Composition of Board of Directors[2]	Average number	Deviation from all other provinces	Comments
Elected members	7.6	N.S.	
Appointees	5.6	.009	Higher
Citizens	10.8	N.S.	
Other members	12.8	N.S.	
Total members*	**13.7**	**N.S.**	

* Total does not always correspond to the sum of the variables considered due to information missing from questionnaires.

Table 9.6 (cont'd)

Budget (average) (2)	$	Deviation from all other provinces	Comments
Public centres	2,042,629	N.S.	
Private centres	1,362,691	N.S.	
Centres offering services to the entire population of a territory	1,902,012	N.S.	
Centres offering services to a specific population	750,393	N.S.	
Centres offering health services	2,509,401	N.S.	
Centres offering social services	734,885	.04	Higher
Centres offering integrated services	1,985,724	N.S.	
All centres in the province	**1,451,379**	**.05**	**Higher**

Table 9.6 (cont'd)

Average recurrent proportion of budget (2)	%	Deviation from all other provinces	Comments
Province	92	.000	Higher recurrent proportion
All other provinces	69		

(1) N = 49

(2) T-test used to analyze difference between provincial and national averages (continuous random variables)

(3) Chi-square test used to analyze differences (nominal variables)

MANITOBA

The 41 centres in Manitoba resemble the centres in the other provinces in terms of the following features: under general characteristics of years of existence, status, target population and nature of services offered; types of services offered; human resources; accessibility; composition of the Board of Directors; average budget; and recurrent portion of budget.

The 41 Manitoba centres differ from the other centres studied in the following respects:

- the centres are more likely to have been created through the joint initiative of public and private bodies;
- a higher proportion of the centres are located in urban areas;
- the populations are more ethnically heterogeneous;
- home care is offered less frequently;
- the average number of positions in the public centres is below the national average;
- there is greater public participation in the assessment of needs and in decision making; and
- the average budget of the centres offering social services is higher.

The development of community health and social services seems to have slowed over the past five years. In Manitoba, the main issue does not appear to be whether the services are controlled by the government or the community; rather, the priority is ensuring public access to services — making services available where needed. Although there are two government departments involved, health care staff and social service staff are integrated at the community level. The centres located in rural areas are multi-service centres.

Table 9.7

Interprovincial Comparisons
Manitoba(1)

Characteristics	%	Deviation from all other provinces	Comments
Years of existence (2)			
1 to 10 years	37	N.S.	
11 to 20 years	38		
21 years and more	25		
Founding body(3)			
Public	05	.05	Fewer public bodies; more "public and private"
Private	58		
Public and private	37		
Centre's status (3)			
Public	8	N.S.	
Private non-profit	92		
Target population (3)			
Total population	44	N.S.	
Specific population	56		
Territory served (3)			
Urban	73	.008	More urban only; less mixed
Rural	20		
Other	7		
Population's ethnic composition(3)			
Homogeneous	40	.03	More heterogeneous
Heterogeneous	67		
Nature of services offered(3)			
Health only	---	N.S.	
Social only	58		
Health and social	42		

Table 9.7 (cont'd)

Types of services(2)	%	Deviation from all other provinces	Comments
Information and referral	95	N.S.	
Health education	70	N.S.	
Organizing and participating in public opinion campaigns	59	N.S.	
Participation in coalitions	68	N.S.	
Primary prevention	76	N.S.	
Setting up community groups	60	N.S.	
Establishing self-help groups	54	N.S.	
Outreach	77	N.S.	
Minor health emergencies	31	N.S.	
Psycho-social services	65	N.S.	
Medical consultations	42	N.S.	
Psycho-social consultations	70	N.S.	
Social reintegration services	72	N.S.	
Specialized medical services	12	N.S.	
Home care	25	.03	Less frequent
Loaning space	58	N.S.	
Loaning staff	53	N.S.	

Table 9.7 (cont'd)

Human resources(2)	Average number per centre	Deviation from all other provinces	Comments
Health centres	-----	----	
Social centres	19.7	N.S.	
Integrated services centres	31.7	N.S.	
All centres in the province	**24.4**	**N.S.**	
Public organizations	18.3	.03	Lower, N = 3
Private organizations	24.5	N.S.	
Centres offering services to the entire population	31.5	N.S.	
Centres offering services to a specific population	21.0	N.S.	
Paid staff (positions)	24.4	N.S.	
Volunteers, unpaid staff (persons)	29.2	N.S.	

Table 9.7 (cont'd)

Accessibility[2]	Rating	Deviation from all other provinces	Comments
Province's rating on index	12.8	N.S.	
Average rating of all other respondents on index	12.5		

Participation[2]	Rating	Deviation from all other provinces	Comments
Province's rating on index	13.1	.010	Higher
Average rating of all other respondents on index	10.2		

Composition of Board of Directors[2]	Average number	Deviation from all other provinces	Comments
Elected members	10.8	N.S.	
Appointees	2.4	N.S.	
Citizens	10.4	N.S.	
Other members	3.8	N.S.	
Total members*	**13.5**	**N.S.**	

*** Total does not always correspond to the sum of the variables considered due to information missing from questionnaires.**

Table 9.7 (cont'd)

Budget (average) [2]	$	Deviation from all other provinces	Comments
Public centres	967,191	N.S.	N = 2
Private centres	1,085,148	N.S.	
Centres offering services to the entire population of a territory	1,289,992	N.S.	
Centres offering services to a specific population	876,152	N.S.	
Centres offering health services	----------	----------	No centres of this type
Centres offering social services	965,465	.05	Higher
Centres offering integrated services	1,213,335	N.S.	
All centres in the province	**1,067,155**	**N.S.**	

Table 9.7 (cont'd)

Average recurrent proportion of budget (2)	%	Deviation from all other provinces	Comments
Province	77.7	N.S.	
All other provinces	72.0		

(1) N = 41

(2) T-test used to analyze difference between provincial and national averages (continuous random variables)

(3) Chi-square test used to analyze differences (nominal variables)

SASKATCHEWAN

The 44 centres in Saskatchewan resemble the centres in the other provinces in terms of the following features: status, territory served, most of the types of services offered, number of volunteers, accessibility, participation, the average budget of private centres, and average recurrent portion of budget.

The province's 44 centres differ from the other centres studied in the following respects:

- the average age of the centres is lower;
- the centres were more frequently founded through the initiative of public bodies and less frequently through the initiative of private bodies;
- the centres are more likely to offer services to the entire population of a territory;
- the population is more ethnically heterogeneous;
- there is a higher proportion of centres offering integrated services, a lower proportion of centres offering social services only;
- the following services are offered less frequently: participation in coalitions, establishing self-help groups, outreach, and social reintegration services;
- the average number of paid positions in all centres is lower (except for health care centres);
- the average number of appointees on the Board of Directors is lower; and
- the average budget of all the centres is smaller.

The Department of Health has chosen to deliver home care using a community approach, which is reflected in our data by the significant proportion of public community health organizations in this province.

Table 9.8

Interprovincial Comparisons
Saskatchewan(1)

Characteristics	%	Deviation from all other provinces	Comments
Years of existence (2)			
1 to 10 years	71		
11 to 20 years	18	.000	Younger
21 years and more	11		
Founding body(2)			
Public	27		More public bodies;
Private	46	.01	fewer private bodies
Public and private	27		
Centre's status (2)			
Public	25	N.S.	
Private non-profit	75		
Target population (2)			
Total population	63	.02	More "total"
Specific population	37		
Territory served (2)			
Urban	46		
Rural	20	N.S.	
Other	34		
Population's ethnic composition(2)			
Homogeneous	35	.04	More heterogeneous
Heterogeneous	65		
Nature of services offered(2)			More integrated;
Health only	16		fewer "social only"
Social only	29	.005	
Health and social	55		

Table 9.8 (cont'd)

Types of services[a]	%	Deviation from all other provinces	Comments
Information and referral	99	N.S.	
Health education	80	N.S.	
Organizing and participating in public opinion campaigns	44	N.S.	
Participation in coalitions	46	.04	Less frequent
Primary prevention	62	N.S.	
Setting up community groups	60	N.S.	
Establishing self-help groups	49	.03	Less frequent
Outreach	50	.04	Less frequent
Minor health emergencies	40	N.S.	
Psycho-social services	64	N.S.	
Medical consultations	49	N.S.	
Psycho-social consultations	65	N.S.	
Social reintegration services	41	.007	Less frequent
Specialized medical services	7	N.S.	
Home care	55	N.S.	
Loaning space	55	N.S.	
Loaning staff	35	N.S.	

Table 9.8 (cont'd)

Human resources[a]	Average number per centre	Deviation from all other provinces	Comments
Health centres	17.6	N.S.	
Social centres	5.8	.000	Lower
Integrated services centres	20.8	.03	Lower
All centres in the province	**15.9**	**.039**	**Lower**
Public organizations	18.1	.000	Lower
Private organizations	15.1	N.S.	
Centres offering services to the entire population	21.1	.02	Lower
Centres offering services to a specific population	7.5	.01	Lower
Paid staff (positions)	15.9	.039	Lower
Volunteers, unpaid staff (persons)	45.2	N.S.	

Table 9.8 (cont'd)

Accessibility[2]	**Rating**	**Deviation from all other provinces**	**Comments**
Province's rating on index	11.8	N.S.	
Average rating of all other respondents on index	12.7		

Participation[2]	**Rating**	**Deviation from all other provinces**	**Comments**
Province's rating on index	9.0	N.S.	
Average rating of all other respondents on index	10.7		

Composition of Board of Directors[2]	**Average number**	**Deviation from all other provinces**	**Comments**
Elected members	9.3	N.S.	
Appointees	1.5	.001	Lower
Citizens	9.6	N.S.	
Other members	1.8	.02	Lower
Total members*	**11.2**	**N.S.**	

*** Total does not always correspond to the sum of the variables considered due to information missing from questionnaires.**

Table 9.8 (cont'd)

Budget (average) (a)	**$**	**Deviation from all other provinces**	**Comments**
Public centres	300,546	.000	Lower
Private centres	545,921	N.S.	
Centres offering services to the entire population of a territory	697,313	.03	Lower
Centres offering services to a specific population	127,878	.000	Lower
Centres offering health services	171,357	.01	Lower
Centres offering social services	140,120	.000	Lower
Centres offering integrated services	785,817	N.S.	
All centres in the province	**484,577**	**.03**	**Lower**

Table 9.8 (cont'd)

Average recurrent proportion of budget (3)	%	Deviation from all other provinces	Comments
Province	70.5	N.S.	
All other provinces	72.8		

(1) N = 44

(2) T-test used to analyze difference between provincial and national averages (continuous random variables)

(3) Chi-square test used to analyze differences (nominal variables)

ALBERTA

The 33 centres in Alberta resemble centres in the other provinces in terms of the following features: general characteristics (except for the nature of the services offered), accessibility, participation, composition of the Board of Directors (except for elected members), average budget and average recurrent portion of budget.

The 33 Alberta centres differ from the other centres studied in the following respects:

- the percentage of centres offering health care is higher;
- outreach work is done more frequently; home care is offered less frequently;
- the average number of volunteers is above the national average; and
- the average number of elected members on the Board of Directors is above the national average.

The legislation governing Family and Community Support Services (FCSS) establishes a model which provides for community services to be financed according to the level of municipal involvement. The legislation is very flexible, including preventive aspects and promoting community involvement in the identification of problems and the elaboration of solutions. The low level of funding allocated for the application of this legislation, however, constitutes the main obstacle to its effectiveness.

Table 9.9

Interprovincial Comparisons
Alberta[1]

Characteristics	%	Deviation from all other provinces	Comments
Years of existence [2]			
1 to 10 years	39		
11 to 20 years	16	N.S.	
21 years and more	45		
Founding body[3]			
Public	9		
Private	70	N.S.	
Public and private	21		
Centre's status [3]			
Public	9	N.S.	
Private non-profit	91		
Target population [3]			
Total population	39	N.S.	
Specific population	61		
Territory served [3]			
Urban	64		
Rural	18	N.S.	
Other	18		
Population's ethnic composition[3]			
Homogeneous	36	N.S.	
Heterogeneous	64		
Nature of services offered[3]			
Health only	21		More centres offering health services
Social only	53	.05	
Health and social	27		

Table 9.9 (cont'd)

Types of services[a]	%	Deviation from all other provinces	Comments
Information and referral	94	N.S.	
Health education	73	N.S.	
Organizing and participating in public opinion campaigns	48	.04	More frequent
Participation in coalitions	50	N.S.	
Primary prevention	81	N.S.	
Setting up community groups	59	N.S.	
Establishing self-help groups	67	N.S.	
Outreach	90	.004	More frequent
Minor health emergencies	36	N.S.	
Psycho-social services	74	N.S.	
Medical consultations	34	N.S.	
Psycho-social consultations	58	N.S.	
Social reintegration services	58	N.S.	
Specialized medical services	10	N.S.	
Home care	20	.01	Less frequent
Loaning space	60	N.S.	
Loaning staff	30	N.S.	

Table 9.9 (cont'd)

Human resources[2]	Average number per centre	Deviation from all other provinces	Comments
Health centres	33.3	N.S.	
Social centres	12.6	N.S.	
Integrated services centres	44.0	N.S.	
All centres in the province	**25.5**	**N.S.**	
Public organizations	46.3	N.S.	
Private organizations	23.5	N.S.	
Centres offering services to the entire population	47.1	N.S.	
Centres offering services to a specific population	11.6	N.S.	
Paid staff (positions)	25.5	N.S.	
Volunteers, unpaid staff (persons)	101.5	.03	Higher

Table 9.9 (cont'd)

Accessibility(2)	**Rating**	**Deviation from all other provinces**	**Comments**
Province's rating on index	13.2	N.S.	
Average rating of all other respondents on index	12.5		

Participation(2)	**Rating**	**Deviation from all other provinces**	**Comments**
Province's rating on index	11.5	N.S.	
Average rating of all other respondents on index	10.6		

Composition of Board of Directors(2)	**Average number**	**Deviation from all other provinces**	**Comments**
Elected members	10.8	.04	Higher
Appointees	2.8	N.S.	
Citizens	10.4	N.S.	
Other members	2.2	N.S.	
Total members*	12.6	N.S.	

*** Total does not always correspond to the sum of the variables considered due to information missing from questionnaires.**

Table 9.9 (cont'd)

Budget (average) (2)	**$**	**Deviation from all other provinces**	**Comments**
Public centres	1,546,666	N.S.	
Private centres	932,040	N.S.	
Centres offering services to the entire population of a territory	1,621,746	N.S.	
Centres offering services to a specific population	557,182	N.S.	
Centres offering health services	1,253,230	N.S.	
Centres offering social services	421,340	N.S.	
Centres offering integrated services	1,887,444	N.S.	
All centres in the province	**989,661**	**N.S.**	

Table 9.9 (cont'd)

Average recurrent proportion of budget (2)	%	Deviation from all other provinces	Comments
Province	71.6	N.S.	
All other provinces	72.7		

(1) N = 33

(2) T-test used to analyze difference between provincial and national averages (continuous random variables)

(3) Chi-square test used to analyze differences (nominal variables)

BRITISH COLUMBIA

The 37 centres in British Columbia resemble centres in the other provinces in terms of the following features: general characteristics (except for the ethnic composition of the population served), most of the types of services offered, human resources, accessibility, participation, average budget and average recurrent portions of budget.

The 37 British Columbia centres differ from the other centres studied in the following respects:

- the populations served are more ethnically heterogeneous;
- the centres are more likely to be involved in setting up community groups and in outreach work than the other centres studied;
- B.C.'s community centres are less likely to offer minor health emergency services and home care than the other centres studied; and
- the total number of Board members and the number of appointees are lower than in the other centres studied.

Table 9.10

Interprovincial Comparisons
British Columbia(1)

Characteristics	%	Deviation from all other provinces	Comments
Years of existance (2)			
1 to 10 years	41		
11 to 20 years	43	N.S.	
21 years and more	16		
Founding body(2)			
Public	11		
Private	78	N.S.	
Public and private	11		
Centre's status (2)			
Public	5	N.S.	
Private non-profit	95		
Target population (2)			
Total population	59	N.S.	
Specific population	51		
Territory served (2)			
Urban	46		
Rural	16	N.S.	
Other	38		
Population's ethnic composition(2)			
Homogeneous	22	.000	More heterogeneous
Heterogeneous	78		
Nature of services offered(2)			
Health only	6		
Social only	70	N.S.	
Health and social	24		

Table 9.10 (cont'd)

Types of services(3)	%	Deviation from all other provinces	Comments
Information and referral	97	N.S.	
Health education	75	N.S.	
Organizing and participating in public opinion campaigns	71	N.S.	
Participation in coalitions	69	N.S.	
Primary prevention	64	N.S.	
Setting up community groups	86	.01	More frequent
Establishing self-help groups	76	N.S.	
Outreach	82	.05	More frequent
Minor health emergencies	16	.02	Less frequent
Psycho-social services	80	N.S.	
Medical consultations	24	N.S.	
Psycho-social consultations	68	N.S.	
Social reintegration services	52	N.S.	
Specialized medical services	6	N.S.	
Home care	19	.007	Less frequent
Loaning space	47	N.S.	
Loaning staff	32	N.S.	

Table 9.10 (cont'd)

Human resources(2)	**Average number per centre**	**Deviation from all other provinces**	**Comments**
Health centres	82.5	N.S.	N = 2
Social centres	21.4	N.S.	
Integrated services centres	83.2	N.S.	
All centres in the province	**39.8**	**N.S.**	
Public organizations	82.5	N.S.	N = 2
Private organizations	37.3	N.S.	
Centres offering services to the entire population	48.2	N.S.	
Centres offering services to a specific population	31.7	N.S.	
Paid staff (positions)	39.8	N.S.	
Volunteers, unpaid staff (persons)	52.4	N.S.	

Table 9.10 (cont'd)

Accessibility(2)	Rating	Deviation from all other provinces	Comments
Province's rating on index	12.7	N.S.	
Average rating of all other respondents on index	12.5		

Participation(2)	Rating	Deviation from all other provinces	Comments
Province's rating on index	11.4	N.S.	
Average rating of all other respondents on index	10.6		

Composition of Board of Directors(2)	Average number	Deviation from all other provinces	Comments
Elected members	7.3	N.S.	
Appointees	1.9	.02	Lower
Citizens	7.6	N.S.	
Other members	1.0	.05	Lower
Total members*	**9.3**	**.03**	**Lower**

*** Total does not always correspond to the sum of the variables considered due to information missing from questionnaires.**

Table 9.10 (cont'd)

Budget (average) [2]	**$**	**Deviation from all other provinces**	**Comments**
Public centres	----------	----	
Private centres	814,353	N.S.	
Centres offering services to the entire population of a territory	949,046	N.S.	
Centres offering services to a specific population	694,626	N.S.	
Centres offering health services	----------	----	
Centres offering social services	451,320	N.S.	
Centres offering integrated services	1,822,777	N.S.	
All centres in the province	**814,353**	**N.S.**	

Table 9.10 (cont'd)

Average recurrent proportion of budget (2)	%	Deviation from all other provinces	Comments
Province	75.1	N.S.	
All other provinces	72.3		

(1) N = 37

(2) T-test used to analyze difference between provincial and national averages (continuous random variables)

(3) Chi-square test used to analyze differences (nominal variables)

In conclusion, we note that it is primarily in the following categories that the interprovincial variations found tend not to be significant: composition of the Board of Directors, accessibility, types of services, general characteristics and participation.

While the centres studied have a number of common elements, there remain interprovincial differences in average number of positions and size of budget — i.e., the variables that determine the size of the organization. The centres with the smallest budgets and least staff tend to be found in the Atlantic provinces and Saskatchewan. While few of the provinces stand out in a statistically significant way in terms of budgets and staff, there are notable exceptions: in Ontario, the average budget is higher than the overall average for the other centres studied; the average budget of the centres offering social services and the average recurrent portion of the budget are also higher. In Manitoba, the difference between the budgets of the centres offering social services and those of the other centres as a whole is significant at .05. In Quebec, the public centres have more staff and larger budgets due to the existence of the CLSC system; at the same time, private community organizations in Quebec have significantly less staff and smaller budgets than respondents of this type in the other provinces.

Chapter 10

PERSPECTIVES

In the preceding chapters, we have presented only objective data relating to verifiable facts (such as number of years of existence, number of paid employees and volunteers, size of budget). The questionnaire also included some questions which asked for opinions or perceptions. While these lack the objectivity of the other questions, they nonetheless add to our understanding of the subject under study. The present chapter deals with questions of this type. Among other things, it contains information and analysis of respondents' perceptions of the role and responsibilities of government with respect to community health and social services.

The Role of Government

The table on the following page shows respondents' reactions to a series of statements on the role government should play in relation to community centres (Table 10.1).

These statements were intended to translate into operational terms three possible attitudes towards the responsibilities of government. Some of them reflect a "neo-liberal" attitude, others a "welfare state" attitude, still others a

Table 10.1

VARIABLE	STATEMENT	AGREE		DISAGREE		NO OPINION		TOTAL	
		N	%	*N*	%	*N*	%	*N*	%
029	The government should officially recognize community service centres by providing them with a specific legal framework limited to orientations, aims and general criteria	182	60	78	26	44	14	286	100
030	The government should define action strategies and specific programs at the local operations level	179	55	29	9	120	36	328	100
031	The government should delegate real and substantial powers to the centres' Boards of Directors	214	68	60	19	42	13	316	100
032	The government should allow the law of supply and demand to prevail between health and/or social service professionals and their clients, provided that law and public order are upheld	135	42	108	33	80	25	323	100
033	The government should provide 100% of the centres' funding	128	40	163	51	26	9	317	100
034	The government should provide more than 50% of the centres' funding	218	73	57	19	23	8	298	100
035	The government should provide less than 50% of the centres' funding	30	10	245	81	28	9	303	100
036	The government should appoint the majority of Board members	4	1	314	94	17	5	325	100
037	The government should appoint a minority of Board members	50	15	247	76	29	9	326	100
038	The government should play no role in the appointment of Board members	254	78	49	15	22	7	325	100

"community approach" as defined in Chapter 1 of the present study.

Three statements express a neo-liberal approach:

- the government should allow the law of supply and demand to prevail between professionals and clients;
- the government should provide less than 50% of the centres' funding;
- the government should play no role in the appointment of Board members.

This vision of "less government" is in tune with some current policies aimed at the privatization of services.

The welfare state approach is expressed by the following statements:

- the government should define action strategies and specific programs;
- the government should provide 100% of the centres' funding;
- the government should appoint the majority of Board members.

This is a vision in which the state intervenes massively in the community sector and directs it according to its own priorities, while ensuring the sector's entire funding.

The community approach represents an intermediate position between the other two. It is expressed in the following statements:

- the government should officially recognize community centres by providing a legal framework for such centres;
- the government should delegate real and substantial powers to the Boards of Directors;
- the government should provide over 50% of the centres' funding;
- the government should appoint only a minority of Board members.

This position assigns government a limited role and does not advocate a hands-off attitude, as does the neo-liberal approach; at the same time, it seeks to create zones of autonomy at the local and community level. Public funding should be substantial and sufficient to sustain action at the local and community level, without becoming the sole source of funding as in the welfare state approach.

While recognizing that ideological positions are never found in an entirely pure state, we had hypothesized that our respondents would favour the community approach, given the nature of the organizations studied. This hypothesis could not be confirmed statistically but the answers allow us to identify some points of consensus among respondents. First, we find that the statements we had grouped together do in fact reflect the approaches we had identified. The table of correlations

(Table 10.2) shows that the coefficients of correlation are indeed highest when a given variable is cross-tabulated with the postulated approach. This is true in all cases, except for the suggestion that the government name the majority of Board members. This attitude, which should logically correspond to the welfare state approach, was so consistently rejected by our respondents (94% disagreed) that the coefficients of both negative and positive correlation are very low. This indicates that even the advocates of extensive government involvement in this sector do not favour a government takeover of community institutions through the Boards of Directors.

Table 10.2

Correlation Between Approaches to Government Involvement and the Variables Describing the Approaches

VARIABLES	DIMENSIONS		
	WELFARE STATE	COMMUNITY	NEO-LIBERAL
Var 029	.2225	.6713	-.1653
Var 030	.6394	.1368	-.0369
Var 031	.1815	.5839	-.1398
Var 032	.0602	-.1807	.7734
Var 033	.8042	-.1160	-.0645
Var 034	.0109	.5251	-.4097
Var 035	-.3430	-.4401	.4928
Var 036	.1522	.0951	-.1479
Var 037	.1303	.4882	-.3142
Var 038	-.1026	-.2887	.5147

Table 10.3 shows the correlations among the three approaches. The level of correlation among the approaches is generally low. While we find a weak correlation between the welfare state and community approaches (.2016), we find an opposition between the neo-liberal and community approaches (-.4479).

Table 10.3

Correlations Among Neo-Liberal, Welfare State and Community Approaches

	WELFARE STATE	COMMUNITY
Community	.2016	1.000
Neo-liberal	-.0996	-.4479

Based on this evidence, it would appear that we are dealing with different, coherent views concerning the role of government in the community services sector.

If we analyze the answers in greater detail, we find stronger support for the community perspective among our respondents than for the other two approaches. Three of the statements expressing this point of view received over 60% support. Only the statement concerning government involvement in the composition of the Boards of Directors did not receive this level of support, garnering only 15% support whereas the statement we had associated with the neo-liberal tendency, which held that government should play no role in the appointment of Board members, received 78% support. Upon reflection, however, the latter view does not appear to be incompatible with the community approach for it favours local autonomy. The exclusion of the government from the appointment of Board members can therefore be consistent with a community perspective.

It is interesting to note that respondents favour substantial government funding for their centres. 73% of respondents believe the government should provide over 50% of their budgets. A large percentage (51%), however, opposes 100% government funding. In our opinion, this reflects a desire for local and community autonomy, which is entirely consistent with the community approach as we described it in Chapter 1.

Most Suitable Level of Government

The statements concerning the role and functions of government were couched in general terms, without reference to any particular level of government. We also asked a specific question, however, to identify the level of government the centres consider best suited to defining their orientations and contributing to their operations and funding.

Table 10.4

Most Suitable Level of Government for Community Sector Functions

Level of Government	Orientations		Function Operations		Funding	
	N	%	*N*	%	*N*	%
Federal	(24)	10	(9)	4	(30)	12
Provincial	(93)	40	(102)	43	(116)	48
Municipal	(36)	15	(40)	17	(9)	4
None	(59)	25	(64)	27	(15)	6
Combination of two or three levels	(22)	10	(22)	9	(71)	30
Total	**(234)**	**100**	**(237)**	**100**	**(241)**	**100**

Table 10.4 shows clearly that a large percentage of respondents (40% and over) believe that it is the provincial government which ought to be involved in the centre's orientations, operations and funding. The municipal level comes second for orientations and operations, while the federal government places second when it comes to funding.

We note that over 25% of respondents want no government interference in orientations and operations.

These results must be treated with caution as data for Quebec and Ontario are not included: the version of the questionnaire distributed to centres in Quebec and Ontario did not contain this question. On the basis of a preliminary comparative study of Quebec and Ontario, however, we may conclude that had the same question been asked in those provinces, the results would have tended even more strongly in the same direction. Quebec respondents would certainly have increased the percentage of centres favouring the provincial government, while Ontario respondents would have boosted the figures for the municipal level.

On the basis of these data and taking into account the observations made throughout the preceding chapters, it would appear that the provincial government is the major public player in the policies, orientations, operations and funding of community health and social services.

The Cooperative Model as a New Approach

In 1984, a national task force on the development of cooperatives in Canada made some recommendations concerning health co-ops. At the conclusion of its study, the task force concluded that the cooperative model could provide an appropriate approach towards rethinking organizational forms for the delivery of some health services. This model could, in particular, apply to community health or social service centres or to multi-service community centres using an integrated services model. The questionnaire included some of the recommendations of this task force and asked for respondents' reactions. The answers are presented in Table 10.5.

We find that the cooperative model, or at least the task force recommendations concerning the development of cooperatives, received extensive support from respondents, except for the recommendation for per capita funding. It must be noted, however, that there was a high percentage of undecideds, which may indicate a certain caution or lack of knowledge, given the novelty of the cooperative formula. We therefore proceeded to conduct an analysis of the answers provided by the centres in Saskatchewan, where health cooperatives have existed for nearly three decades and are therefore a familiar phenomenon to respondents (see Table 10.6).

In Saskatchewan, where respondents should logically be more familiar with the cooperative health centre model, we find a lower percentage of undecideds. We do not, however, find a higher level of positive responses; there is, rather, slightly greater disagreement with the recommendations of the task force in Saskatchewan than in the rest of the country, where there is generally a lower level of familiarity with the phenomenon. Nevertheless, the majority of Saskatchewan respondents support the cooperative model, as do respondents as a whole.

Table 10.5

Centres' Opinions on Cooperative Formula

RECOMMENDATION	AGREE		DISAGREE		DON'T KNOW		TOTAL	
	N	%	*N*	%	*N*	%	*N*	%
The cooperative sector should take the lead in spurring the creation and growth of co-ops in the health care (and social services) sector.	176	52	31	9	135	39	342	100
The co-op sector should sponsor a nation-wide conference on developing a cooperative system of health care (and social services).	173	51	53	16	112	33	338	100
Each province should create and finance an independent agency to assist cooperative development.	186	55	41	12	110	33	337	100
The federal government should participate with the provinces in funding the initial costs of setting up and phasing in new co-ops.	204	61	38	11	93	28	335	100
Provincial governments should provide co-ops with a per capita amount for each of their members, equivalent to the average sum which is spent annually per capita on health care (and social services) under the current system.	110	34	55	17	160	49	325	100
Co-ops should be free to use any budget surpluses to improve or increase services as they see fit.	225	69	19	6	84	25	328	100
Membership in health care (and social service) co-ops should remain a voluntary option, for a fixed, renewable period.	186	57	28	9	113	34	327	100
Co-ops should retain the general features of the present health care (and social service) system: public administration, universality, mobility and accessibility.	179	55	29	9	120	36	328	100

Table 10.6

Saskatchewan Respondents' Opinions on Cooperative Formula

RECOMMENDATION	AGREE		DISAGREE		DON'T KNOW		TOTAL	
	N	%	*N*	%	*N*	%	*N*	%
The cooperative sector should take the lead in spurring the creation and growth of co-ops in the health care (and social services) sector.	22	50	6	14	16	36	44	100
The co-op sector should sponsor a nation-wide conference on developing a cooperative system of health care (and social services).	22	51	8	19	13	30	43	100
Each province should create and finance an independent agency to assist cooperative development.	23	53	8	19	12	28	43	100
The federal government should participate with the provinces in funding the initial costs of setting up and phasing in new co-ops.	27	64	7	17	8	19	42	100
Provincial governments should provide co-ops with a per capita amount for each of their members, equivalent to the average sum which is spent annually per capita on health care (and social services) under the current system.	15	39	9	24	14	37	38	100
Co-ops should be free to use any budget surpluses to improve or increase services as they see fit.	28	68	4	10	9	22	1	100
That membership in health care (and social service) co-ops should remain a voluntary option, for a fixed, renewable period.	22	55	7	18	11	27	40	100
Co-ops should retain the general features of the present health care (and social service) system: public administration, universality, mobility and accessibility.	25	63	6	15	9	22	40	100

Perceptions of Community Members

Respondents' perceptions of community members constitute in our view one determinant of community intervention orientations. The following question was put to respondents:

"On a day-to-day basis, how are members of the community perceived by the Centre's personnel (in real rather than ideal terms)?

- Mainly as clients or patients to be treated or helped.
- Mainly as citizens and beneficiaries who are entitled to the services provided by the Centre's personnel.
- Mainly as citizens capable of organizing and becoming partners in solving their own problems and those in their environment."

It must be noted that this question asks for an administrator's opinion on the perceptions of the centre's service providers, which may introduce a bias and produce different results than if the question had been put to the service providers directly. We must therefore exercise caution in interpreting the results (see Table 10.7).

Table 10.7

Perceptions of Users

	TYPE OF SERVICE PROVIDER					
	Health services		Social services		Total	
Perception	*N*	%	*N*	(%)	*N*	%
Clients to be treated (helped)	(42)	28	(30)	10	(72)	16
Entitled beneficiaries	(38)	26	(56)	19	(94)	21
Citizens capable of organizing	(35)	23	(95)	32	(130)	29
Mixed perceptions	(34)	23	(112)	39	(146)	33
Total	**(149)**	**100**	**(293)**	**100**	**(492)**	**100**

We might expect that, in keeping with the philosophy of community intervention, the majority of service providers would perceive the public as capable of organizing. In fact, 29% of respondents believe that the service providers see the public in this light, 21% believe that they see the public as beneficiaries who are entitled to receive service, and a smaller percentage (16%) believe they see the public as clients to be treated or helped.

When the results are broken down by the service provider's field (social services or health care), we find that administrators believe that social workers are less likely to perceive the public as clients to be treated or helped than are health workers (10% as opposed to 28%).

Importance of Goals and Procedures

We may suppose that a community centre would consider it very important that its goals be accepted by the community, for after all the objectives of an institution that defines itself as community-based must derive their legitimacy from the community; this is another aspect of public participation. For similar reasons, we may say that the public should not be subjected to procedures or instructions that emanate entirely from without and are applied rigidly and mechanically. While it is most important that procedures and instructions be clear and understandable and that they be distributed to all, it is equally important that they be applied flexibly and allow for the new situations which always arise in community life. In other words, it is not essential that all eventualities be foreseen, nor that procedures and instructions always be rigorously applied. Spirit and atmosphere count here as well as organizational mechanics.

Respondents' reactions to four statements on this subject are presented in Table 10.8.

Table 10.6

Relative Importance of Goals and Procedures

STATEMENT	VERY IMPORTANT %	FAIRLY IMPORTANT %	NOT VERY IMPORTANT %	TOTAL %
The Centre's objectives must be accepted by management and staff	95	4	1	100
The Centre's objectives must be accepted by the population which the Centre serves	70	27	3	100
Procedures and instructions should provide for all eventualities	29	51	20	100
Procedures and instructions should always be rigorously applied	16	56	28	100

Respondents consider the legitimacy of goals very important; i.e., they must be accepted by management, staff and the public. It would appear, however, that the staff is considered more important than the population itself in the legitimation of goals, which may be a surprising attitude to find in a community centre. It must be recognized, however, that if the goals are not accepted by staff, it will be very difficult for the centre to meet community needs; this may explain the responses of the centre administrators, even if they do not reflect the most community-oriented attitude possible.

With respect to the application of procedures, the results indicate considerable flexibility in adapting procedures to the various situations encountered by the centres. The majority of respondents consider this aspect of centre management relatively unimportant.

In this chapter, we have seen that the centres studied answered certain questions concerning their orientations in a way that was predictable and generally consistent with the orientations supposed by our community intervention model (see Chapter 1).

Based on the results, we may state that the majority of respondents view the role of government from a community perspective. At the same time, a significant percentage of respondents see the co-op model as a new form of organization that is worth exploring.

Finally, a smaller number of the centres than anticipated (29%) view the populations they serve as capable of organizing, as partners. It is difficult to draw any firm conclusions on this question as opinions were sharply divided.

Conclusions

The present study has enabled us to produce a fairly thorough description of the general characteristics of 368 community health and social service centres in all ten provinces, the types of services they offer, their human resources, their accessibility, the public participation they allow, and their financial situation. We were also able to organize the information on these objective questions by province and to compare the data for each province with the figures for the rest of the country. The final chapter presents a brief examination of the centres' outlooks based on the answers to certain questions on orientations.

Despite some theoretical and methodological difficulties inherent in the nature and complexity of the subject and the ill-defined outlines of the field of study, the information we have presented here gives an account of a phenomenon of growing importance in Canada in these final years of the '80s. We wished to make a contribution to the state of knowledge on community health and social service centres by collecting data as systematically as possible and analyzing them as rigorously as possible. Some questions, however, presented problems of interpretation and there remain many grey areas which would require more thorough study, even if some issues are now better defined.

We deliberately presented the data very briefly, with the least interpretation possible. At the conclusion of this work, we believe that the figures speak for themselves and that some main trends concerning the phenomenon under study have emerged.

Beyond the concrete data on matters such as the centres' years of existence or modest size, some facts have become clearer because they have been documented and quantified.

The Importance of Interprovincial Differences

If there is a constant running through this study, it is certainly the significance of interprovincial variations. Throughout this report, we have seen that provincial governments are, in many ways, the most significant and determining level of government for the development of the community health and social service centres studied. This finding will certainly come as no surprise to experts in the field; what is striking in the results is the extent of the phenomenon. The evidence is so pronounced that we believe it demonstrates that there are as many models as there are provinces. The major issues for community health and social service centres are played out at the level of provincial policy choices. The centres studied depend on the political will and socioeconomic circumstances of the provinces. Each provincial situation creates an environmental context which determines the number of centres, their characteristics and their development.

The Importance of Legal Status

We also found that the great majority of the centres studied are private non-profit organizations, which seems to reflect the situation in the sector quite accurately. Even in Quebec, where there is a public network of local community service centres, there are still more private non-profit organizations.

Clear differences between public and private non-profit centres also emerged. The public centres are generally larger and have more human resources and larger budgets than the private non-profit centres. The private non-profit centres operate primarily in the social services field while the public centres are more often health centres delivering services according to a multi-service model in which health and social services are integrated.

The Importance of the Nature of Services

The third structural factor for understanding the community sector is the nature of the services offered. The centres differ significantly depending on whether they offer health services, social services or comprehensive integrated services. Health centres and integrated multi-service centres are similar in terms of their main characteristics; the major difference is found between community health centres and community social service centres.

Validation of the Community-Based Model

According to the literature consulted, the distinction between a community approach strategy based on a territorial community and one based on a community of interest or values is an important factor in defining community centres and understanding the organizational models in place. We have seen the importance of this factor in our analysis, for it has allowed us to distinguish the characteristics of the centres studied.

Analysis of the type and range of services offered by the centres studied revealed three levels of services which are always interrelated in a community approach:

- the individual with his or her specific, concrete needs;
- the individual in his or her environment;
- the environment itself and the organizational structures found in the community.

Access to the community centres, the type of staff, the contribution of volunteers, public participation, the composition and operation of the Board of Directors, and the operation and management of the centres are all factors which illustrate how the theoretical model set forth in Chapter 1 is translated into practice in the organizations studied. In general, we may say that respondents' answers confirm that we are dealing with a Canada-wide phenomenon which has original aspects but is consistent with what we had postulated on the basis of the literature consulted.

This study should prove useful in a number of areas, including policy, planning and the organization of community services. First and foremost, however, it provides each community health and social service centre with an opportunity to analyze and compare itself with a set of Canadian centres of the same type in a fairly systematic way, though it is still subject to improvement. If this study gives individual centres and the thousands of administrators, volunteers, managers and staff members an opportunity to take stock of the organizations in which they work, to strengthen their community orientations and to refine their interventions, it will have achieved all the goals that the research team set at the outset. This was, in the first instance, a social development project and it is our most sincere hope that it will answer the needs of the main interested parties: the community health and social service centres and the communities they serve.

Appendix 1

INTER-PROVINCIAL COMPARATIVE STUDY OF LOCAL COMMUNITY-TYPE CENTRES FOR SOCIAL AND HEALTH SERVICES

Study conducted by the Canadian Council
on Social Development

INFORMATION CONCERNING THE CENTRES

Notes

- The aim of this questionnaire is to gather factual information in order to draw up a province by province profile of local community-type centres for health and social services in Canada. It has four parts: general information, orientations, operations, and funding.
- Due to the kind of information requested, the questionnaire is to be completed by a person in a position of responsibility within the Centre.
- The questionnaire requires the Centre's point of view rather than the personal opinion of the respondent.
- All information gathered with the help of this questionnaire will be treated CONFIDENTIALLY, in such a way that it will be impossible in the final report to identify the opinion of any respondent in particular.
- The term "centre" is used in a general sense.
- Unless otherwise indicated, most answers require only a check mark (✓) or an "x" in the appropriate space provided.

GENERAL INFORMATION

1

1. Name of the Centre:__________________ ☐☐☐ 2 3 4

2. Telephone number:(___)______________

3. Address:
   . street_____________________
   . city_______________________
   . postal code________________

4. Province:___________________________ ☐☐ 5 6

5. For how many years has the Centre been offering health and/or social services?____________ ☐☐ 7 8

6. Whose decision was it to create the Centre? (several answer are possible)

   The federal government ☐
   The provincial government ☐
   The municipal government ☐ ☐☐☐ 9 10 11
   Volunteer association(s) ☐
   Private individual(s) ☐
   Public-sector institution(s) ☐
   Other(s) (specify): ____________ ☐

7. Has the Centre been incorporated?

   Yes ☐
   No ☐ ☐ 12

If the Centre is not incorporated, please return the blank questionnaire.

8. What is the legal status of the Centre as specified in its Charter? (eg. private non-profit, public, etc.)

   ______________________________ ☐ 13

9. Does the Centre offer its services to the entire population in its territory, or to one or several specific groups only? (one answer only)

To the entire population in its territory ☐

To only one or several specific groups (eg. elderly persons, young people, handicapped persons, etc.) ☐
if so specify: ______________
____
____

☐☐ 14 15

The next two questions pertain to the entire population to be served by the Centre, not just the sector of the population which is in fact reached by the Centre.

10. Is the Centre operating in an urban, semi-urban or rural area?

An urban area ☐
A semi-urban area ☐
A rural area ☐

☐ 16

11. In terms of ethnic groups, is the population fairly homogeneous or heterogeneous (two or three fairly large groups)?

Homogeneous ☐
Heterogeneous ☐

☐ 17

ORIENTATIONS

12. What are the main services provided by the Centre?

Health services only ☐
Social services only ☐
Health and social services ☐
Other(s) (specify): ______________ ☐
____
____

☐ 18

13. What kind of approach is taken with direct users of services and the community in general?

Curative approach only ☐
Preventive approach only ☐
Curative and preventive approach ☐

☐ 19

14. Does the population take part in identifying and analyzing the community's social and/or health needs?

Yes ☐
No ☐ (proceed to Question 15)

☐ 20

If so, in what way(s)? (Answer yes or no in each case)

	Yes	No	
Citizens or users elected to the Board of Administration	☐	☐	☐ 21
Representatives of volunteer groups from the community elected to the Board	☐	☐	☐ 22
Advisory groups set up by the Centre, which include citizens	☐	☐	☐ 23
Surveys to identify needs conducted in the community	☐	☐	☐ 24
Representative(s) from one or more municipalities on the Board	☐	☐	☐ 25
Other(s) (specify):__________	☐	☐	☐ 26
__________________________			☐ 27 ☐ 28
__________________________			

15. When decisions are being made to set up services or programs in the Centre, does the population take part in the decision-making process?

Yes ☐
No ☐ (proceed to Question 16)

☐ 29

If so, in what way(s)? (Answer yes or no in each case)

	Yes	No	
Citizens or direct users elected to the Board of Administration	☐	☐	☐ 30
Representatives of volunteer groups from the community elected to the Board	☐	☐	☐ 31
Committees with decision-making powers and set up by the Centre, which include citizens	☐	☐	☐ 32
Representative(s) of one or more municipalities on the Board	☐	☐	☐ 33
Other(s) (specify): ____________ ______________________ ______________________	☐	☐	☐ 34 ☐☐ 35 36

16. On a day-to-day basis, how are members of the community perceived by the Centre's personnel (in real rather than ideal terms)?

	Health staff	Social staff	
Mainly as clients or patients to be treated or helped	☐	☐	
Mainly as citizens and beneficiaries who are entitled to services set up by the Centre's personnel	☐	☐	☐☐☐ 37 38 39
Mainly as citizens capable of organizing themselves and becoming partners in solving their own problems and those in their environment	☐	☐	☐☐☐ 40 41 42

17. Please give the Centre's opinion on each of the following statements relating to government responsibility towards community-type centres for health and social services.

Statement	Agree	Dis-agree	No opinion	
The government should provide a specific legal framework for community service centres (one dealing only with the orientations, aims and general criteria of such centres) so as to recognize them officially	☐	☐	☐	☐ 43
The government should define action strategies and specific programs at the local level of operations	☐	☐	☐	☐ 44
The government should delegate real and substantial powers to the centres' boards of administration	☐	☐	☐	☐ 45
The government should allow the law of supply and demand to operate between health and/or social service professionals and their clients, provided that law and public order are upheld	☐	☐	☐	☐ 46
The government should provide 100% of the centres' funding	☐	☐	☐	☐ 47
The government should provide more than 50% of the centres' total budget	☐	☐	☐	☐ 48
The government should provide less than 50% of the centres' total budget	☐	☐	☐	☐ 49
The government should nominate the majority of members of the centres' boards of administration	☐	☐	☐	☐ 50
The government should nominate a minority of members of the centres' boards of administration	☐	☐	☐	☐ 51
The government should not in any way take part in the process of nominating members of the centres' boards of administration	☐	☐	☐	☐ 52

18. In your opinion, what level of government would be most suitable for ensuring public responsibility vis-à-vis community centres, in terms of their basic orientations, operations (personnel, management, services, etc.) and financing?

	Federal	Provincial	Municipal	None	
Orientations	☐	☐	☐	☐	☐ 53
Operations	☐	☐	☐	☐	☐ 54
Financing	☐	☐	☐	☐	☐ 55

19. In your opinion, to what extent would the Centre see the following statements as important?

Statements	Very important	Fairly important	Hardly important	
The Centre's objectives must be accepted by management and staff	☐	☐	☐	☐ 56
The Centre's objectives must be accepted by the population which the Centre serves	☐	☐	☐	☐ 57
Procedures and instructions should make advance provisions for all eventualities	☐	☐	☐	☐ 58
Procedures and instructions should always be rigorously applied	☐	☐	☐	☐ 59

20. A national task force has analyzed the question of co-operative health systems and concludes that such a system might provide a very appropriate response to the main problems of the current health systems (i.e. costs, institutionalization, lack of prevention, etc.). This model might be of particular interest to community health centres (as well as, in our view, local centres offering social services).

What is the Centre's opinion of the following recommendations drawn up by this task force?

Recommendations	Agree	Disagree	Don't know	
Given the tradition of non-profit local community services in Canada:				
the cooperative sector should take the lead in spurring the creation and growth of co-ops in the health (and social) services sector.	☐	☐	☐	☐ 60
To spread the idea of the health (and social) services co-ops and enlist support from the public authorities, the population and the current health (and social) services system:				
the co-op sector should sponsor a nation-wide conference on developing a co-operative system of health care (and social) services.	☐	☐	☐	☐ 61
Considering the strong government presence in the current system of health (and social) services; considering inter-provincial differences; considering the need for a trial period:				
each province should create and finance an independant office to assist co-operative development;	☐	☐	☐	☐ 62

Recommendations	Agree	Disagree	Don't know	
the federal government should participate with the provinces in funding the initial costs of setting up and phasing in new co-ops.	☐	☐	☐	☐ 63
Over and above the various modes of funding currently used:				
provincial governments should provide co-ops with a per capita amount for each of their members, equivalent to the average sum which is spent annually per capita on health (and social) services within the current system;	☐	☐	☐	☐ 64
co-op should be allowed to use their surplus budgets to improve or increase their services in their own way.	☐	☐	☐	☐ 65
Considering the rather individualistic behavior and current expectations of users of health (and social) services:				
participation in health (and social) services co-ops should remain a voluntary option, for a fixed, renewable period;	☐	☐	☐	☐ 66
co-ops should maintain the general characteristics of the present health (and social) services system: public administration, universality, portability and comprehensive access would remain as they are now.	☐	☐	☐	☐ 67

2

OPERATIONS

☐☐☐ 2 3 4

21. What type of personnel is employed by the Centre and in what numbers? (number: full-time equivalent)

Status	Type of personnel	Number	
Paid personnel (salary, honorarium, session contract, etc.)	Doctors (G.P.s or specialists)	____	☐☐☐ 5 6 7
	Midwives	____	☐☐☐ 8 9 10
	Practitioners of natural or alternative medecine	____	☐☐☐ 11 12 13
	Nurses	____	☐☐☐ 14 15 16
	Health assistants or technicians	____	☐☐☐ 17 18 19
	Other health professionnals (specify): ______________________ ______________________________	____	☐☐☐ 20 21 22
	Clinical social workers with university training	____	☐☐☐ 23 24 25
	Assistants or technicians in clinical social work	____	☐☐☐ 26 27 28
	Community workers with university training (eg. community organizers, social organizers, "outreach" workers, etc.)	____	☐☐☐ 29 30 31
	Assistants or technicians in community organization	____	☐☐☐ 32 33 34
	Other professionnals in the human sciences (eg. psychologists, psycho-educators, criminologists, etc.) (specify): ______________ ______________________________	____	☐☐☐ 35 36 37
	Self-taught persons (without specific initial training or with different professional training) working in:		
	. health care	____	☐☐☐ 38 39 40
	. social care	____	☐☐☐ 41 42 43

Status	Type of personnel	Number	
	Administrative and support personnel	___	☐☐☐ 44 45 46
	Other(s) (specify): ______________________________	___	☐☐☐ 47 48 49
Unpaid personnel (do not count members of the Board of Administration)	Volunteers (with specific training)	___	☐☐☐ 50 51 52
	Volunteers (without specific training)	___	☐☐☐ 53 54 55
	Other(s) (specify): ______________________________	___	☐☐☐ 56 57 58

22. Is the Centre able to serve ethnic minorities in their own language?

Yes ☐
No ☐
Not applicable ☐

☐ 59

23. Does the Centre have members of the community's ethnic minorities on its staff?

Yes ☐
No ☐
Not applicable ☐

☐ 60

24. What are the Centre's office hours?

Mon.	from______	to______	61 ☐☐ 6
Tue.	from______	to______	63 ☐☐ 6
Wed.	from______	to______	65 ☐☐ 6
Thur.	from______	to______	67 ☐☐ 6
Fri.	from______	to______	69 ☐☐ 7
Sat.	from______	to______	71 ☐☐ 7
Sun.	from______	to______	73 ☐☐ 7
			75 ☐☐ 7

25. Has the Centre established a formal emergency service which is open during periods when the Centre is closed?

Yes ☐ (proceed to Question 27)
No ☐
Not applicable ☐ (proceed to Question 27)

☐ 77

26. Is it possible for a person or a group from the community to reach a member or members of the Centre's personnel, in the event of an urgent need?

No ☐
Yes, but with difficulty ☐
Yes, quite easily ☐
Yes, very easily ☐

☐ 78

27. How would you describe the physical accessibility of the Centre in relation to the community it is to serve?

Location	Adequate	☐	
	Fairly adequate	☐	☐ 79
	Hardly adequate	☐	
Office	Adequate	☐	
	Fairly adequate	☐	☐ 80
	Hardly adequate	☐	
Means of public transportation	Adequate	☐	☐☐☐ 2 3 4
	Fairly adequate	☐	
	Hardly adequate	☐	☐ 5
Means of communication (eg. telephone, radio, etc.)	Adequate	☐	
	Fairly adequate	☐	☐ 6
	Hardly adequate	☐	

☐3

28. How many members may sit on the Board of Administration, according to the Centre's constitution or statutes?

Number ______

☐☐ 7 8

29. Indicate the number of members on the Board of Administration, and the mode of recruitment employed?

Status	Modes of recruitment: Elected No.	Chosen No.	Mandated by work No.	
Users of the services	___	___	___	☐☐☐ 9 10 11
Representatives of volunteer organizations and/or pressure groups from the milieu	___	___	___	☐☐☐ 12 13 14
Representatives of the population in general	___	___	___	☐☐☐ 15 16 17

Status	Modes of recruitment Elected No.	Chosen No.	Mandated by work No.	
Representatives of personnel from the Centre	___	___	___	☐☐☐ 18 19 20
Representatives of the federal government	___	___	___	☐☐☐ 21 22 23
Representatives of the provincial government	___	___	___	☐☐☐ 24 25 26
Representatives of the municipality (ties)	___	___	___	☐☐☐ 27 28 29
Representatives of public agencies or organizations	___	___	___	☐☐☐ 30 31 32
Representatives of volunteers from the Centre	___	___	___	☐☐☐ 33 34 35
Director of the Centre	___	___	___	☐☐ 36 37
Other(s) (specify): ________	___	___	___	☐☐☐ 38 39 40
________________				☐☐ ☐☐ 41 42 43

30. What is the term of office for members of the Board of Administration?

Unspecified term ☐
Set periods (specify): ☐
____

☐☐
45 46

31. Are ethnic minorities represented on the Board of Administration?

Yes ☐
No ☐
Not applicable ☐

☐
47

32. Indicate the number of regular board meetings per year?

Number ______

☐☐
48 49

33. Is the Centre's personnel grouped into teams, modules, or any other type of structure?

Yes ☐
No ☐ (proceed to Question 35)
Partially ☐

☐ 50

34. Are the teams uni- or multi-disciplinary?

All uni-disciplinary ☐
All multi-disciplinary ☐
In some cases uni-disciplinary, and in others multi-disciplinary ☐

☐ 51

(Proceed to Question 36)

35. What is the reason for not having work teams?

Not enough staff to form one or more teams ☐

Choice of an individualized organization of work for personnel ☐

Other(s) (specify): ☐

____

____

☐☐ 52 53

36. Which of the following services have been offered by the Centre in the last twelve (12) months (to individual or group users and to the general community)?

	Yes	No	
Information and referral services regarding health and social laws and services	☐	☐	☐ 54
Health education (groups to promote awareness, public education campaigns, etc.)	☐	☐	☐ 55
Organizing or participating in public campaigns for social change	☐	☐	☐ 56

	Yes	No	
Primary prevention (eg. prenatal courses, courses in effective parenting or personnal development, immunization, etc.)	☐	☐	☐ 57
Participation in coalitions or in groups promoting legislative or policy changes in the health or social field	☐	☐	☐ 58
Setting up and supporting community groups aimed at improving conditions in the environment (eg. shelters for battered women, proper housing, tenants' associations, etc.)	☐	☐	☐ 59
Establishing self-help groups in the health or social sphere	☐	☐	☐ 60
Outreach work	☐	☐	☐ 61
Services for minor health emergencies	☐	☐	☐ 62
Psycho-social services (crisis situation)	☐	☐	☐ 63
Psycho-social consultations	☐	☐	☐ 64
Regular services provided by general practitioners (consultation, treatment, follow-up)	☐	☐	☐ 65
Social reintegration services	☐	☐	☐ 66
Specialized medical services	☐	☐	☐ 67
Home care	☐	☐	☐ 68
Loaning halls or equipment to groups for community activities	☐	☐	☐ 69

	Yes	No	
Loaning staff	☐	☐	☐ 70
Other(s) (specify): ____________ ____________________	☐	☐	☐☐ 71 72

37. Insofar as the Centre employs doctors, how are they remunerated?

Payment per intervention ☐
Salary ☐
Honoraria or payment by session ☐ ☐ 73
Other(s) (specify):____________ ☐
____
Not applicable ☐

38. Does the Centre belong to a group of community organizations?

Yes ☐ ☐ 74
No ☐

If so, at what level does this group intervene?

Local level ☐
Regional level ☐ ☐☐☐ 75 76 77
Provincial level ☐
National level ☐

39. Over the past twelve (12) months, what work relations has the Centre had with the other resources from the community?

The Centre has established short-term and occasional relations with the other resources ☐

The Centre has established on-going collaboration with the other resources ☐ ☐ 78

The Centre has worked independantly of other resources, for the most part. ☐

FUNDING

4

40. What is the total budget of the Centre for the 1987-1988 fiscal year (including, possibly, protected budget allotments)?

☐☐☐ 2 3 4

Budget ____________

☐☐☐☐☐ 5 6 7 8 9

41. In your opinion, is the overall budget sufficient for carrying out the Centre's mission?

Yes ☐
No ☐

☐ 12

If not, what budget would be required: ____________

☐☐☐☐☐ 13 14 15 16 17

42. What are the Centre's direct sources of funding and their relative importance for the 1987-1988 fiscal year (including unconfirmed sources)?

☐ 20

Sources	Amount
Public	
Federal (ministries or government agencies)	________
Provincial (ministries or government agencies)	________
Municipal	________
Private and/or Community Sources	
United Way (Centraide)	________
Others (eg. foundations, religious orders, business, unions, social clubs, individual donors, etc.)	________
Self-funding	
(eg. dues, operational income, fund-raising, investment income, etc.)	________

☐☐☐☐☐ 21 22 23 24 25

☐☐☐☐☐ 28 29 30 31 32

☐☐☐☐☐ 35 36 37 38 39

☐☐☐☐☐ 42 43 44 45 46

☐☐☐☐☐ 49 50 51 52 53

☐☐☐☐☐ 56 57 58 59 60

43. For the 1987-1988 fiscal year, what proportion of the Centre's funding is recurrent?

Recurrent proportion:________%

☐☐ 63 64

44. For the 1987-1988 fiscal year, what are the Centre's modes of funding?

Global subsidy ☐

Funding on a case-by-case basis or per volume of clients ☐

Funding by specific program ☐

Funding on a per capita basis (cooperative system) ☐

Other(s) (specify):____________ ☐

____

☐☐☐ 65 66 67

45. Over the last twelve (12) months, has the Centre set up new programs or services?

Yes ☐
No ☐ (proceed to Question 47)

☐ 68

46. How has the Centre financed these new programs or services?

Budget re-allocation ☐
New funds ☐
Other(s) (specify):____________ ☐
____

☐ 69

47. In general, does the Centre feel that its financial backers respect and promote its autonomy in terms of orientations, policies and programs (to the extent, of course, that the Centre generally complies with the basic criteria for receiving funds)?

Yes ☐
No ☐
Not applicable ☐
Comments (if necessary)______________________
____
____

☐ 70

48. What would be the most appropriate mode of funding for the Centre?

Global subsidies in relation to services ☐

Global subsidies on a per capita basis ☐

Funding on a case-by-case basis, or per volume of clientele ☐

Funding by specific programs ☐

Other(s) (specify):______________ ☐

____

☐ 71

49. Insofar as the Centre employs doctors, what would be the best method of payment for this category of professionals?

Payment per intervention ☐

Salary ☐

Honoraria or payment by session ☐

Other(s) (specify):______________________ ☐

☐ 72

GENERAL COMMENTS:

We would like to thank you for your kind co-operation and assure you once again of the confidentiality of your answers.

Please send the completed questionnaire in the pre-addressed envelope which you find enclosed.

Thank you!

Jean-Bernard Robichaud
Claude Quiviger
Canadian Council on Social
Development
515 Viger Street East
Suite 410
Montréal, Québec
H2L 2P1

THE CANADIAN COUNCIL ON SOCIAL DEVELOPMENT
MEMBERSHIP INFORMATION

As a member of the Council,

- you support work aimed at improving our social and economic environment;
- you participate in a network of people who share your social commitment;
- you are continuously informed of innovative ideas and major developments as they occur.

You are entitled to:

- *Perception*, our bilingual magazine on social development;
- Three quarterly national newsletters;
  Overview, a review of social issues, trends and programs in Canada;
  Initiative, serving the self-help community;
  Vis-à-vis, exploring developments in the field of family violence;
- Preferential rates for participation in Council conferences and workshops;
- Information on new publications;
- The Council's annual report;
- Voting privileges at annual meetings;
- 20% off our regular prices for books and reports.

Membership Fees	
Individuals:	
Full-time students	$20
Participating	$50
Sustaining	$100
Organizations:	
Annual budget	
less than $100,000	$75
$100,001 to $300,000	$125
over $300,000	$200
Associate	$500
Libraries:	$50
Municipalities:	
per 1,000 population (minimum fee $100)	$2.75

To become a member, provide us with your name, the name of your organization (if applicable), complete address, membership category, and send along with your cheque to: CCSD Membership Services, 55 Parkdale Avenue, Ottawa, Ontario, K1Y 4G1.Tel.: (613) 728-1865; Fax: (613) 728-9387.

The CCSD is a non-profit organization registered under the Income Tax Act relating to charities. Tax receipts are issued for all donations and financial contributions.

Membership Application

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THE CANADIAN COUNCIL ON SOCIAL DEVELOPMENT

FOUNDED IN 1920, the Canadian Council on Social Development (CCSD) is an independent, national, non-profit organization. Through research, policy analysis, community consultation and information sharing, the CCSD provides a forum for citizen participation in the formulation of progressive social policies.

The CCSD is the only national organization whose mandate and involvement embrace all aspects of social development and social policy. Since its beginning, the Council has been actively involved in the evaluation of existing programs, the identification of essential improvements, and the promotion of needed developments. It has been a positive, non-partisan advocate of social measures such as universal inoculation, pensions, unemployment assistance, worker's compensation, medicare, legal aid, daycare, and social and cooperative housing.

The Council played an active role in the development of the Canada Assistance Plan and the Child Tax Credit, and has been a promoter of the Guaranteed Annual Income concept, self-help, voluntarism and community economic development.

The CCSD is not a "think tank." It is the only national social research, advocacy and policy organization with an open public membership. CCSD's analyses, opinions, research and information reflect not only highly professional technical work but also the active analysis and shared experience of its broadly representative membership.

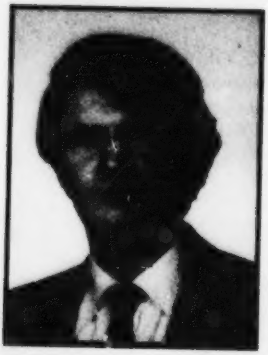
The Council's diverse membership includes concerned individuals as well as representatives from business, labour, government, public and private service organizations, voluntary associations and institutions. An annual meeting of the membership reviews the year's program and financial activities. Council activities are directed by a voluntary, 39-member Board of Governors. Board members are formally elected at the annual meeting for terms of one, two and three years.

The CCSD is a major publisher in the field of social development. Publications include books, research reports, policy briefs and occasional papers, as well as four bilingual periodical publications: *Perception*, Canada's social development magazine; and three quarterly national newsletters — *Overview*, reviewing current developments in social policies and programs; *Initiative*, serving the self-help community; and *Vis-à-vis*, exploring family violence issues.

National headquarters of the Canadian Council on Social Development are located at 55 Parkdale Avenue, Ottawa, Ontario, K1Y 4G1. Tel: (613) 728-1865. Fax: (613) 728-9387. CCSD also has a Quebec office, located at 1074 Berri St., Montreal, Quebec, H2L 4X2. Tel.: (514) 288-1687, Fax: (514) 288-6723.

JEAN-BERNARD ROBICHAUD

Jean-Bernard Robichaud, currently Rector of the Université de Moncton, holds a Ph.D in social administration from the University of Chicago. Until recently, he was the senior policy advisor with the Canadian Council on Social Development, president of the Canadian section of the International Council on Social Welfare, and Vice President of Dernier Recours, a shelter in Montreal. He has authored and co-authored many books and articles and has extensive experience in social services, social work, teaching, research, and administration. He was a scientific advisor to the Rochon Commission (1987/88) studying the reform of Quebec's health and social services and has served on a number of task forces.



CLAUDE QUIVIGER

Claude Quiviger holds a degree in theology from the Université de Strasbourg (France), an M.A. in andragogy from the Université de Montréal and an M.A. in education from the Institut catholique de Paris. He is currently an advisor to the healthy community project for the city of Montreal and is a former policy advisor with the Canadian Council on Social Development. He was founder and general manager of the Centre Mariebourg in Montreal and has more than 20 years experience in community organizing. He has designed, written and organized popular education programs for adults and has co-authored a number of books on education. He is also involved in the community as a volunteer member of many organizations.

This innovative study examines the state of community health and social service centres in all ten provinces of Canada. The authors analyze the orientations, operations and funding of the 368 centres that participated. On the basis of this analysis, they propose a theoretical framework derived from community reality. Comparisons between provinces, between different categories of centres and different types of communities make a concrete contribution to knowledge on the subject. In addition, this study constitutes a reference tool which can help community centres assess their activities. Anyone involved in any capacity in the development of health and social services would benefit from this work.

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